50272-101

REPORT DOCUMENTATION PAGE	1. REPORT NO.	2.	3. Recipient's Accession No. PB96-172804

4. Title and Subtitle
Should Medicare Place Physician Groups at Financial Risk: An Assessment of Alternative Demonstration Strategies

5. Report Date
2/96

6.

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8. Performing Organization Rept. No.
8189-900

9. Performing Organization Name and Address
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10. Project/Task/Work Unit No.

11. Contract(C) or Grant(G) No.
(C) 500-92-0011 (04)
(G)

12. Sponsoring Organization Name and Address
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

13. Type of Report & Period Covered
Final Report
12/93-12/95

14.

15. Supplementary Notes

16. Abstract (Limit: 200 words)

This report assesses the feasibility and desirability of conducting a demonstration in which physician groups would be at financial risk for services provided under Medicare and discusses key design issues that would have to be addressed in developing such a demonstration. Based upon a literature review and discussions with key health industry and Government representatives, the report suggess that such a demonstration would be feasible given the experience that many physician groups have gained accepting financial risk from HMOs and the high level of interest expressed by some groups provided that they are at risk for some inpatient care. The authors identify major obstacles would have to be overcome for a successful demonstration: potential regulatory requirements imposed by state insurance departments and the need for physician groups to offer incentives (i.e. supplemental benefits) for beneficiaries to enroll. The authors conclude that they do not believe that a demonstration of direct risk-based payment to physician groups has as much potential for success as the Medicare Choice demonstration, which involves larger organizations. Given the trend in the marketplace toward greater integration, they do not expect that direct risk-based payment of physician groups other than large IDSs will become an important contracting vehicle for the Medicare program.

17. Document Analysis a. Descriptors
Managed Care
Physician Groups

b. Identifiers/Open-Ended Terms

c. COSATI Field/Group

18. Availability Statement	19. Security Class (This Report)	21. No. of Pages
Release Unlimited	unclassified	
	20. Security Class (This Page) unclassified	22. Price

(See ANSI-Z39.18)
P.O. : Brigid Goody

See Instructions on Reverse

OPTIONAL FORM 272 (4-77)
(Formerly NTIS-35)
Department of Commerce

Contract No.: 500-92-0011(04)
MPR Reference No.: 8189-900

SHOULD MEDICARE PLACE PHYSICIAN GROUPS AT FINANCIAL RISK: AN ASSESSMENT OF ALTERNATIVE DEMONSTRATION STRATEGIES

February 6, 1996

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EXECUTIVE SUMMARY

Fiscal pressures created by the prospect of continuing large Federal budget deficits have focused renewed attention on the growing cost of the Medicare program. Policymakers have become increasingly interested in exploring creative new approaches to make physicians and other providers more cost conscious in their treatment of Medicare beneficiaries. In this report, we assess the feasibility and desirability of the Health Care Financing Administration (HCFA) conducting a demonstration in which physician groups would be at financial risk for services provided under Medicare. Growing numbers of physician groups have entered into risk-based payment arrangements with health maintenance organizations (HMOs), so it is reasonable to investigate whether HCFA could enter into similar payment arrangements with physician groups under the Medicare program. We also discuss key design issues that would have to be addressed in developing such a demonstration.

This project builds on and extends an earlier HCFA-funded project in which Mathematica Policy Research, Inc. (MPR) and the Medical Group Management Association (MGMA) designed a demonstration of direct capitation of medical groups under Medicare (Langwell et al. 1987). The demonstration designed in that project was never implemented. In this project, we consider a broader range of payment arrangements than the previous project and expand the set of potential demonstration participants to include independent practice associations (IPAs) and integrated delivery systems (IDSs) in addition to medical groups. For convenience, we have used the term physician group in this report to include all such organizations.

A. DESCRIPTION OF THE PAYMENT METHODS CONSIDERED

We considered three types of risk-based payment approaches in this report: (1) capitation for some or all Medicare services, possibly with a risk-sharing arrangement between HCFA and the provider groups for noncapitated services; (2) blended capitation and fee-for-service (FFS) payment rates for some or all Medicare services; and (3) incorporation of a risk-sharing arrangement into the existing FFS system. The first two approaches would require an enrollment-model design in which beneficiaries in the demonstration sites would face an explicit choice of whether or not to enroll in a participating physician group. The third payment approach could potentially be implemented under either an enrollment-model or a nonenrollment-model design. In a separate report produced under this project, we assess the feasibility and desirability of a fourth payment method--bundling for selected medical conditions.

Under capitation, physician groups would receive fixed monthly payments from HCFA in exchange for providing directly, or arranging for the provision of, a defined set of Medicare services to enrolled beneficiaries. The capitation payments could cover all Medicare services or a subset of services, such as all Part B services or primary care services. If physician groups were capitated for only a subset of Medicare services, HCFA should adopt a risk-sharing arrangement analogous to those used by HMOs to place the groups at some risk for noncapitated services. This would give physicians incentives to consider the total costs of care for their Medicare enrollees and would eliminate the incentives physicians would otherwise face to shift care from capitated to noncapitated settings (e.g., from ambulatory to inpatient settings).

To operate a risk-sharing arrangement for services not covered under the capitation payment, HCFA would establish a risk-sharing account for each physician group equal to the expected Medicare payments for noncapitated services for the group's enrollees. At year end, if the actual payments for those services were less than expected payments, the group and HCFA would share in the surplus in the risk-sharing account. To require physician groups to share in deficits as well as surpluses in the account, HCFA could withhold a fixed percentage of the capitation payments to the groups and then retain some or all of the withheld funds to cover any year-end deficit in the risk-sharing account. If the account had a surplus, physician groups would receive all the of the withheld funds plus an agreed-upon percentage of the surplus.

Under blended capitation and FFS, physician groups would receive payments from HCFA that would be based in part on capitation and in part on FFS rates. For example, if the capitation/FFS split were 50/50, physician groups would receive capitation payments equal to half the full capitation rates and FFS payments equal to half the full FFS rates on the claims they submit. The capitated portion of the payment would provide incentives for cost efficiency, while the FFS portion would allow payments to vary with the health care needs of patients. The blended capitation/FFS payments could cover all Medicare services or, alternatively, a subset of services such as all Part B services. In the latter case, a risk-sharing arrangement should be used to place physician groups at some risk for Part A services.

If a risk-sharing arrangement were incorporated in the existing FFS system under an enrollment-model design, physician groups would receive FFS payments for services they provide to their enrollees and would participate in a risk-sharing arrangement for other services such as inpatient hospital care. Under a nonenrollment-model design, beneficiaries would not face a choice of whether to enroll in a physician group, and the risk-sharing mechanism would apply to the Medicare patients of the physician groups rather than to beneficiaries who had enrolled in the groups. Although we consider both models in this report, an enrollment-model design would give physician groups much greater ability to manage care, since it would enable them to use the methods used by HMOs and other managed care plans to control costs. For example, beneficiaries who enroll in a demonstration physician group would agree to receive all of their care within the designated provider network (if the group is based on an HMO model) or to pay higher cost-sharing for services received outside the network (if the group is based on a PPO model). In addition, under an enrollment-model design, the group might use other methods to control costs, such as primary care gatekeepers to regulate access to specialty services and inpatient care. In contrast, under a nonenrollment-model design, beneficiaries would retain complete freedom to use providers outside the group.

B. RESEARCH APPROACH

We began this study by investigating the characteristics of physician groups and their experience accepting financial risk from managed care plans. This provided useful background for assessing the potential feasibility of a demonstration of direct risk-based payment to physician groups under Medicare. Next, we assessed the feasibility and desirability of HCFA conducting a demonstration of the three payment approaches described above, based on the following criteria: (1) incentives for physician groups to participate, (2) incentives for beneficiaries to participate, (3) potential to contain costs without

compromising quality of care, (4) absence of significant regulatory barriers, and (5) reasonableness of administrative burden and cost.

The analysis conducted for this report was based on a review of the literature and discussions with key health industry and government representatives. The literature review provided information on recent trends in the organization of physician groups, including the development of IDSs, and the types of payment arrangements physician groups have entered into with managed care plans. We held discussions with senior representatives of physician groups throughout the country and key national associations such as the Medical Group Management Association, the American Group Practice Association, the Unified Medical Group Association, and the American Association of Physician-Hospital Organizations to solicit their views on the payment approaches under consideration and their willingness to participate in a demonstration. We also held discussions with state insurance regulators to obtain their views on any regulatory barriers that would confront a demonstration of the payment methods under consideration.

C. EXPERIENCE OF PHYSICIAN GROUPS WITH RISK-BASED PAYMENT

Many physician groups have gained experience with risk-based payment through their contractual arrangements with HMOs and other managed care plans. A recent survey of HMOs and PPOs conducted by MPR found that about three-quarters of the HMOs that contract with intermediate entities such as medical groups and IPAs for primary care services pay those entities on a capitation basis (Gold et al. 1995). Fifty-seven percent of the network/IPA model HMOs in the survey reported that capitation is the predominant means by which *individual* primary care physicians in their plan are paid (either directly by the HMO or by an intermediate entity).

HMOs typically capitate individual physicians only for a defined set of primary care services, and they capitate medical groups and IPAs for a broader range of services, such as all professional medical services (Kongstvedt 1993). Some HMOs also include inpatient hospital care among the capitated services for large medical groups or IPAs. When specialty referrals and/or inpatient hospital care are excluded from the capitation payment to providers, HMOs typically use a risk-sharing arrangement to give providers incentives to be cost conscious with respect to the use of such services.

HMOs that capitate physician groups or individual physicians typically have a mechanism in place to limit the physicians' financial risk for patients with high-cost illnesses. For example, risk-sharing arrangements for inpatient and/or specialty care generally include a stop-loss provision to limit the extent to which expenses for high-cost patients are counted against the physicians' balance in the risk-sharing account. Physician groups that are capitated by HMOs for all professional medical services, and perhaps inpatient hospital care as well, typically purchase reinsurance from the HMO or from a reinsurance carrier.

The growing competitiveness of the health care industry has prompted many medical groups and IPAs in recent years to merge with other groups and/or align themselves with hospitals to form physician-hospital organizations (PHOs) and other types of IDSs (Lazarus 1994, Shortell et al. 1994). We have included IDSs as possible participants in the demonstrations under consideration in this project because some of the medical groups and IPAs that would be most qualified for the demonstration have already joined with hospitals to form IDSs, and IDSs (because of their size and capital base) are better able to accept the financial risk associated with some of the payment methods under consideration than either

medical groups or IPAs acting alone. Another important development has been the emergence of investor-owned physician management companies that buy medical groups and provide them with management expertise, access to capital, and expertise in negotiating contracts with managed care plans.

D. ASSESSMENT OF THE RISK-BASED PAYMENT METHODS

A demonstration of direct risk-based payment to physician groups under Medicare would allow HCFA to test new payment arrangements that could potentially encourage physicians to manage the care of their Medicare patients more efficiently and generate cost savings for the Medicare program. The experience that many physician groups have gained accepting financial risk from HMOs suggests that a demonstration of direct risk-based payment arrangements between physician groups and the Medicare program is worthy of serious consideration. Our discussions with physician-group representatives revealed a high level of potential interest in such a demonstration among some physician groups. Others expressed reservations about such a demonstration, however, and voiced concerns about the AAPCC methodology (which presumably would be used to set both capitation rates and targets for a risk-sharing arrangement) and the possibility that participation would antagonize the HMOs with which they contract. There was unanimous agreement that physician groups would be interested in such a demonstration only if they were at some risk for inpatient hospital care. This reflects the widespread recognition that reductions in inpatient costs have been identified as the primary source of savings under managed care.

Despite the apparent promise of a demonstration of risk-based payment to physician groups under Medicare, we identified two critical obstacles that would have to be overcome for such a demonstration to be feasible. First, state insurance departments would likely impose regulatory requirements on physician groups seeking to participate in such a demonstration that many such groups would be unable to meet. Specifically, the insurance regulators we interviewed for this project felt that, except for large integrated delivery systems (IDSs), few physician groups would be able to meet the requirements concerning insolvency protection that state insurance departments would likely impose. They noted that physician groups accepting risk directly from Medicare would be viewed very differently from a regulatory perspective than physician groups accepting risk from HMOs. In the latter situation, the HMO is the entity held legally responsible by the state insurance department to ensure that consumers are protected. In the former situation, however, the physician group would be considered the legally responsible entity and would therefore be subject to regulatory requirements analogous to those imposed on HMOs. Thus, if HCFA decides to proceed with such a demonstration, close consultation with the National Association of Insurance Commissioners (NAIC) would be necessary in the initial planning stages.

HCFA is also facing this issue with the Medicare Choices Demonstration, which is expected to include IDSs among the set of participants that will accept financial risk under Medicare. HCFA has indicated that, to participate in the Choices demonstration, IDSs must meet state licensure requirements--or, in the absence of appropriate state licensure laws, they must contact the relevant regulatory authority to seek guidance concerning the safeguards necessary to participate. We believe that a demonstration of the type considered in this report should also require that physician groups obtain approval to participate from state insurance departments and/or other relevant state authorities.

The second critical obstacle that would have to be overcome for a demonstration of direct risk-based payment to physician groups to be feasible concerns the need for physician groups to offer incentives for beneficiaries to enroll in a group and then, once enrolled, receive most or all of their care within the group's

designated provider network. A key factor affecting this issue is that over three-quarters of the Medicare population has supplemental insurance. To enroll significant numbers of beneficiaries and effectively manage their care, physician groups would need to offer a supplemental insurance product that is less expensive than comparable supplemental products on the market. Thus, physician groups would need to offer a product comparable to that offered by Medicare HMOs or Medicare SELECT plans. The insurance product offered by the physician groups would incorporate incentives for beneficiaries to receive care within the groups' provider network, either by providing no coverage for services outside the network (as in Medicare risk HMOs) or by requiring higher cost-sharing for out-of-network services (as in PPOs). If physician groups did not offer a supplemental insurance product, beneficiaries who enrolled in a group while retaining their supplemental coverage would have no financial incentive to remain within the group's network, since they would retain full Medicare and supplemental coverage for out-of-network services.

Most physician groups do not have the expertise to develop, market, and administer a supplemental insurance product, however, so this could be a major barrier to participation for physician groups other than large IDSs that own an HMO or are financially integrated in some way with an insurer. Furthermore, obtaining approval from state insurance regulators to market a supplemental insurance product would also be a significant barrier to participation for most physician groups.

If these two critical obstacles could be overcome, we believe a demonstration of direct risk-based payment to physician groups would be feasible. We assume HCFA would want to distinguish such a demonstration from the Medicare Choices Demonstration by primarily targeting medical group practices and IPAs--and perhaps smaller, less fully integrated IDSs. The Choices demonstration will provide HCFA an opportunity to enter into risk-based payment arrangements with larger, more fully integrated IDSs that are able to provide directly, or through contractual arrangements with other providers, all Medicare Part A and Part B services. Since these larger, more fully integrated IDSs will be tested in the Choices demonstration, we assume HCFA would not make them a focus of the type of demonstration considered in this report.

We have identified some other issues that could potentially hinder the success of a demonstration of direct risk-based payment to physician groups under Medicare. We do not believe these issues are so critical as to prevent HCFA from proceeding with a demonstration to test this type of payment arrangement. HCFA should be aware of these issues, however, in assessing the potential value of such a demonstration and in determining the priority to assign this initiative within its overall demonstration and research agenda. First, the physician groups that would be most capable of participating in this type of demonstration are those that currently provide Medicare services under risk-based payment arrangements with Medicare risk HMOs. A demonstration involving these physician groups could potentially disrupt the Medicare HMO program, however, since it could result primarily in a migration of Medicare beneficiaries from HMOs to the participating physician groups, with little or no net increase in the percentage of beneficiaries enrolled in managed care arrangements. Furthermore, some of the physician-group representatives we interviewed suggested that many such physician groups would be reluctant to participate in such a demonstration, since the HMOs with which they contract would view this as a competitive threat and might retaliate by canceling or failing to renew their contracts with the groups.

These considerations suggest that if HCFA were to implement such a demonstration, it should primarily target physician groups that do not serve significant numbers of Medicare patients under risk-

based payment arrangements with HMOs.[35] Such physician groups are likely to require more technical assistance, more careful monitoring, and a longer transition period to become successful at managing financial risk for a Medicare population than physician groups that have already acquired this experience by contracting with Medicare HMOs. The potential advantage of this strategy is that it could provide a vehicle for introducing more limited forms of risk-based payment in market areas where HMOs have little or no participation in the Medicare risk program.

A second issue concerns the trade-offs involved in choosing a risk-based payment method for the demonstration. Full capitation for all Medicare services would provide the greatest incentives for cost control. This approach would likely be very burdensome administratively for many medical group practices and IPAs, however, since it would require that they have contractual arrangements with Part A providers and systems in place for paying those providers. Medical groups that do not already have such systems in place would probably not be willing to invest the resources to develop them for the sake of a demonstration. Thus, for many medical groups, the most feasible risk-based payment methods are likely to be those in which Part A providers would be paid under the regular Medicare program. These include (1) capitation for Part B services, with a risk-sharing arrangement for Part A services; (2) capitation for primary care services, with a risk-sharing arrangement for other Medicare services; (3) blended capitation and FFS for some or all Part B services, with a risk-sharing arrangement for Part A services; and (4) incorporation of a risk-sharing arrangement into the FFS system.

The results of MPR's evaluation of the Medicare risk HMO program raise questions as to whether groups operating under these payment systems could achieve measurable savings in inpatient hospital costs, which is critical since reductions in inpatient costs have been widely cited as a key mechanism through which managed care plans reduce the costs of care. The MPR evaluation found that Medicare HMOs reduce the number of inpatient days for their Medicare enrollees by shortening lengths of stay rather than reducing admission rates (Brown et al. 1993). But in a demonstration of risk-based payment to physician groups in which Part A providers would be paid under the regular Medicare program, physician groups would have no incentive to try to reduce lengths of stay, since doing so would not reduce the Medicare payments to hospitals under the DRG system. Thus, a major vehicle by which Medicare HMOs have been found to reduce the costs of care would not be available to physician groups under such a demonstration. Physician groups might be able to achieve cost savings in other ways, however, such as reducing enrollees' use of specialists and expensive tests. In addition, there may be some market areas in which physician groups could reduce admission rates for Medicare beneficiaries.

In sum, we do not believe a demonstration of direct risk-based payment to physician groups has as much potential for success as the Medicare Choices Demonstration, which will involve larger organizations such as IDSs, PPOs, and HMOs capable of providing the full range of Medicare Part A and Part B services. Given the trend in the marketplace toward greater integration of physicians, hospitals, and other providers, we believe that contracting with larger, more fully integrated IDSs holds more promise than contracting with medical groups and IPAs that are not organized as IDSs. Thus, we do not expect that direct risk-based payment of physician groups other than large IDSs will become an important contracting vehicle for the Medicare program. HCFA may want to pursue such arrangements on an opportunistic basis through small-scale demonstrations, however, to supplement its other risk-based contracting arrangements

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[35]Prior experience with risk-based payment for other populations should be among the eligibility criteria, however.

and to test such an approach in market areas where HMOs, PPOs, and IDSs are not interested in contracting arrangements such as those being tested in the Choices demonstration.

I. INTRODUCTION

A. BACKGROUND AND OBJECTIVES

Since its inception in 1965, the Medicare program has paid for most physician services on a fee-for-service (FFS) basis. Medicare expenditures have increased dramatically under that system. From 1980 to 1992, Medicare expenditures for physician services increased from $7.8 billion to $32.3 billion, an average annual rate of growth of 12.6 percent. After adjusting for general inflation in the economy, Medicare expenditures for physician services per beneficiary nearly doubled during this period, increasing (in 1992 dollars) from $490 in 1980 to $960 in 1992. Physicians influence the growth of Medicare expenditures not only through the services they provide directly but also through their decisions to refer patients to more costly services and providers such as specialty services and inpatient hospital care. Efforts to constrain the growth in Medicare expenditures while preserving access to high quality care should therefore carefully consider the incentives facing physicians and recognize their central role in managing patient care.

In this report, we assess whether HCFA should conduct demonstrations of new payment approaches for physician groups that would place them at direct financial risk for the services they provide to Medicare beneficiaries. Some of the payment approaches would place physician groups at risk for services other than those they provide directly and would thus provide incentives for physicians to be cost conscious in managing the total care of their patients. The primary motivation for considering such payment approaches for Medicare is the growing number of physician groups that are accepting financial risk from health maintenance organizations (HMOs). Thus, we investigate whether HCFA should develop payment arrangements with physician groups under the Medicare program analogous to the types of arrangements they have developed with HMOs.

The risk-based payment approaches we consider fall into three general categories:

- Capitation for some or all Medicare services, possibly with a risk-sharing mechanism between HCFA and the groups for noncapitated services
- Blended capitation and FFS payment rates for some or all Medicare services
- Incorporation of a risk-sharing arrangement between HCFA and the groups in the existing FFS system

In a separate report produced under this contract, we evaluate the feasibility of a fourth payment arrangement--bundling for selected medical conditions.

Under capitation, qualified physician groups would receive fixed monthly payments from HCFA in exchange for providing, or arranging for the provision of, a defined set of Medicare services to a defined set of beneficiaries. The capitation payments could be structured to cover all Medicare Part A and Part B services or a subset of services, such as all Part B services or all primary care services. If physician groups were capitated for only a subset of Medicare services, HCFA could adopt a risk-sharing arrangement similar to those used by HMOs to place physicians at some risk for services excluded from the capitation payment. Such an arrangement would give physicians incentives to consider the total costs of care in treating their Medicare patients and would eliminate the incentives physicians would otherwise face to shift care from capitated to noncapitated settings (e.g., from ambulatory to inpatient settings).

Under blended capitation and FFS, physician groups would receive payments from HCFA that would be based in part on capitation and in part on FFS rates. For example, if the capitation/FFS split were 50/50, physician groups would receive capitation payments equal to half the full capitation rates and FFS payments equal to half the full FFS rates on the claims they submit. The capitated portion of the payment would provide incentives for cost efficiency, while the FFS portion would allow payments to vary with the health care needs of patients. Newhouse (1986, 1994) has recommended blended rates for HMOs as a means of adjusting for risk selection until more sophisticated methods are available.

The third type of payment arrangement we consider would involve incorporating a risk-sharing mechanism into the existing FFS system to give physician groups incentives to be cost-conscious in their care of Medicare patients. This approach could be modeled after the risk-sharing mechanisms used by HMOs that pay physicians on a FFS basis. For example, participating physician groups could receive a year-end bonus if total Medicare Part A and Part B payments for their patients are less than the amount projected by HCFA, based on the patients' characteristics. This approach would allow physician groups to share with HCFA any savings achieved through more effective, less costly management of their patients' care. Such a system could also impose a financial penalty on physician groups if total Medicare payments for their patients exceed the projected amount.

Except where otherwise noted, we consider these three payment approaches as options for paying *physician groups* rather than individual physicians because most specifications of the payment approaches would entail too much financial risk for individual physicians to bear. Physician groups would allow the spreading of risks across a larger Medicare patient load. The types of physician groups that would be most capable of participating in demonstrations of these payment approaches are medical group practices and independent practice associations (IPAs). We also include various types of integrated delivery systems (IDSs) that have developed in recent years as candidates for the demonstrations.

IDSs encompass a range of organizational models in which physicians, at least one hospital, and in some cases other providers, act as a unified contracting agent with managed care plans. IDSs can be formed through various types of contractual arrangements among providers or through common ownership. We include IDSs as possible participants in the demonstrations under consideration rather than focusing strictly on "physician groups" because (1) some of the medical groups and IPAs that would be most qualified for the demonstration have already joined with hospitals to form IDSs; (2) because of their larger size and capital base, IDSs are better able to accept the financial risk associated with some of the payment methods under consideration than medical groups or IPAs; and (3) IDSs are better able to

administer the payment approaches that include both Part A and Part B services in the capitation payment. Throughout this report, we use the term physician group to include IDSs as well as medical groups and IPAs.

We also address several payment design issues in this report to determine if any of the specifications of the three payment approaches are sufficiently promising to warrant future demonstrations. For example, we examine the issues and tradeoff s involved in determining which services should be covered under a capitated system, which payment systems should include a risk-sharing mechanism, and how such a mechanism may be structured. We also address demonstration design issues that would be relevant to most of the payment approaches, such as the appropriate eligibility criteria for screening physician groups seeking to participate.

B. RESEARCH APPROACH

In this report we (1) describe the characteristics of physician groups and their experience in accepting financial risk from managed care plans, and (2) assess the feasibility and desirability of HCFA conducting demonstrations of the three payment approaches described above, given the incentives for physician groups and beneficiaries to participate, institutional and regulatory considerations, and the likely effects on the costs and quality of care.

To describe the characteristics of physician groups and their experience accepting financial risk, we reviewed both the research literature and the health industry trade literature. Although the information in the trade literature is largely anecdotal, this body of literature is very useful for learning about trends and developments that are too recent to have been the subject of scholarly studies published in the research literature. The trade literature also helped us identify organizations and individuals to contact for interviews on topics such as the development of IDSs and the types of payment arrangements physician groups are entering into with HMOs.

To assess the feasibility and desirability of the three payment methods, we interviewed senior representatives of physician groups (broadly defined to include medical groups, IPAs, and IDSs) and key national associations of physician groups. During the interviews we obtained information on their:

- Views on trends and recent developments in the organization and management of physician groups and groups' payment arrangements with HMOs and other managed care plans
- Reactions to the payment methods under consideration, including their assessment of strengths and limitations of each, and barriers to be overcome in implementing a demonstration
- Willingness to participate in a demonstration of each of the various payment methods, and their preferred payment method, if any, among the options under consideration.

We also interviewed representatives of state insurance departments to obtain their views on regulatory barriers that could confront demonstrations of the various payment methods under consideration. In addition, we interviewed representatives of HCFA's Office of Managed Care to obtain their views on the payment methods under consideration, based on their experience overseeing Medicare's current managed care options. A complete list of the persons we interviewed appears in Appendix A.[1]

Drawing on the information we obtained from the literature and the interviews, we assessed the three payment methods using the following criteria:

1. ***Attractiveness to Physician Groups.*** A feasible demonstration of any of the payment methods under consideration must provide adequate incentives for physician groups to participate. Hence, physician groups must regard the payment method as fair, they must not be exposed to excessive financial risk, and they should be allowed to benefit financially if they are successful at managing patient care more cost-effectively than under FFS arrangements.

2. ***Attractiveness to Beneficiaries.*** The success of a demonstration would also depend on the willingness of Medicare beneficiaries to participate. Some of the payment options under consideration, particularly those involving capitation, would impose

[1]Most of the interviews were conducted by telephone. In-person interviews were conducted with persons located in the Washington, DC area and in the case of some persons who were in Washington on business.

restrictions on beneficiaries' choice of providers. The attractiveness of a given payment option to beneficiaries will depend on (a) the degree to which their choice of providers is restricted, and (b) the incentives they are offered to accept those restrictions. In considering these issues, it is important to recognize that most beneficiaries currently have Medicare supplemental insurance that does not restrict provider choice.

3. ***Potential to Contain Costs Without Compromising Quality of Care.*** Before implementing a payment demonstration, HCFA should have a reasonable expectation that it will contain Medicare expenditures without adversely affecting quality of care. Achieving this objective depends on a number of payment and demonstration design features, including: the degree of financial risk imposed on physician groups, the ability of the groups to manage that risk, the incentives for groups to manage patient care so as to consider the total costs of care (i.e., both Part A and Part B), the potential for groups to "game" the payment system, and the mechanisms in place to ensure that high quality care is provided.

4. ***Absence of Regulatory Barriers.*** The feasibility of the various payment options depends on the nature and extent of any barriers imposed by state insurance departments or other regulatory authorities. The views of state insurance regulators and HCFA's Office of Managed Care are particularly relevant for assessing the capitated approaches, in which physician groups would perform functions similar in many respects to those of Medicare risk HMOs.

5. ***Reasonableness of Administrative Burden and Costs.*** To achieve its goals, a payment method should not impose excessive administrative burdens on physician groups or HCFA. If physician groups consider the costs of administering the payment system excessive, they will refuse to participate or withdraw from participation. Similarly, HCFA must consider the increased costs of administering the system, since these costs will at least partially offset any savings achieved through reductions in benefit payments.

C. RELATIONSHIP OF THIS PROJECT TO OTHER HCFA INITIATIVES

The payment approaches considered in this project are designed to provide incentives for physicians to more effectively manage the care of their Medicare patients. These approaches fit into HCFA's strategy of expanding the role of managed care in the Medicare program. Currently, about 9 percent of Medicare beneficiaries are enrolled in one of the managed care options available under Medicare--i.e., risk HMOs, cost HMOs, and health care prepayment plans (Vladeck 1995). To help contain Medicare costs, HCFA and many members of Congress are searching for new approaches that would encourage a greater proportion of the Medicare population to enroll in managed care.

One of HCFA's approaches to achieving that objective is to increase the range of managed care options available to the Medicare population. This project is investigating whether that objective can be achieved by placing physician groups at financial risk for defined sets of Medicare beneficiaries. Another HCFA initiative designed to increase the range of managed care options available to Medicare beneficiaries is the Medicare Choices Demonstration, for which HCFA solicited applications from a variety of managed care organizations, including HMOs, PPOs, and IDSs. HCFA encouraged applicants for that demonstration to develop creative approaches that build on managed care innovations in the private sector. Organizations that participate in the Choices demonstration will be required to accept some level of financial risk, with possible payment options ranging from full capitation to various risk-sharing arrangements with HCFA. MPR is assisting HCFA with the design and implementation phases of the Choices demonstration. Initial solicitations for participation in the demonstration were mailed to managed care organizations in selected market areas in June 1995, and based on the responses it received, HCFA selected 52 organizations for further consideration and invited them to submit full applications. HCFA intends to select participants for the demonstration in early 1996.

Another HCFA initiative to examine methods of encouraging physicians to be cost conscious was a study conducted by researchers at Brandeis University that investigated whether HCFA should allow certain physician practices (e.g., large primary care groups or multispecialty groups with a significant primary care component) to opt out of the national Medicare Volume Performance Standards (VPSs) and have the system applied separately for them at the practice level (Tompkins et al. 1995).[2]

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[2]The VPS system is intended to provide a collective incentive for physicians to constrain the volume and intensity of services provided to Medicare beneficiaries. Under the VPS system, Congress annually sets a target rate of increase for Medicare expenditures for physician services, and subsequent fee updates are adjusted downward or upward depending on whether the actual rate of increase nationally exceeds or falls below the target. The VPS system is widely regarded as providing little or no incentive for individual physicians or physician groups to alter their behavior, since their actions have a negligible effect on the growth in national expenditures, which is the relevant measure for determining any adjustments to future fee increases.

Under this approach, a target rate of increase in Medicare expenditures per patient would be established for the physician practice, which would depend on the case-mix of the practice's Medicare patients. Both the target and the actual rate of increase in expenditures would be expressed as expenditures per unique patient seen by the practice. If the actual rate of growth in expenditures per patient was less than the target, the physician practice would be rewarded through a bonus or an upward adjustment in its future fees. The Brandeis study developed alternative models in which the practice-level VPS would be defined over either (1) all services currently covered under the national VPS system; or (2) all Medicare services.[3] The first approach would provide incentives for physician practices to be cost conscious in the services they provide directly and in their referrals for other Part B services; the second approach would add inpatient hospital care and other Part A services to the range of services over which physician practices would have an incentive to be cost conscious.

The practice-level VPS approaches developed in the Brandeis study would not require beneficiaries to enroll in a physician practice. In contrast, the payment approaches considered in this report that are based on full or partial capitation (including blended capitation and FFS) would require formal enrollment by beneficiaries in physician groups. The approach we consider in which a risk-sharing arrangement between HCFA and the groups would be incorporated in the FFS system would not necessarily require an enrollment decision, although as we discuss in Chapter III, it would enable physician groups to be more effective at controlling costs.

In general, a demonstration based on an enrollment model would give physician groups greater ability to manage their patients' care, since by enrolling in a group, beneficiaries would have agreed to abide by the group's utilization management procedures. These might include, for example, a gatekeeper to control

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[3]The national VPS system covers, with a few exceptions, services on claims processed by Medicare Part B carriers. It also covers Part B physician services provided in outpatient hospital settings (facility services are not included), for which claims are submitted to the Medicare fiscal intermediaries (FIs) rather than the carriers.

access to specialists and inpatient hospital care. As we discuss below, however, it may be a challenge for physician groups to develop incentives to encourage significant numbers of beneficiaries to enroll. By not requiring an enrollment decision, the practice-level VPS approaches avoid one of the challenges that would confront the payment approaches being considered in this project. The trade-off is that physician groups under the practice-level VPS approaches would have less ability to manage their patients' care, since their patients would retain the freedom to self-refer to specialists and use hospital services without the knowledge or approval of the physician group.

D. GUIDE TO THIS REPORT

This report consists of four chapters. In Chapter II, we provide background information on the characteristics of medical group practices, IPAs, and IDSs, and discuss their experience accepting risk-based payments from HMOs and other managed care plans. In addition, we discuss regulatory issues concerning such payment arrangements. In Chapter III, we describe in greater detail the capitation, blended capitation and FFS, and FFS with risk-sharing payment approaches under consideration as future Medicare demonstrations. We also evaluate their strengths and limitations using the criteria noted previously. We present our conclusions in Chapter IV.

II. CHARACTERISTICS OF PHYSICIAN GROUPS AND THEIR EXPERIENCE WITH RISK-BASED PAYMENT

In recent years, market pressures to contain health care costs have led to a significant, ongoing transformation of the American health care delivery system. Physicians and other providers are increasingly organizing themselves to improve their competitive position in the market, particularly their ability to obtain contracts with health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Medical groups are merging to create larger groups, and physicians and hospitals are uniting to create physician-hospital organizations (PHOs) and other types of integrated delivery systems (IDSs). Consequently, the number and types of physician groups that could potentially participate in a Medicare demonstration of risk-based payment are much greater than just five years ago. In this chapter, we discuss the characteristics of physician groups, their experience accepting risk-based payment from health plans and employers, and the legal and regulatory issues surrounding such payment arrangements.

A. CHARACTERISTICS OF MAJOR TYPES OF PHYSICIAN GROUPS

As noted in the previous chapter, our definition of physician groups for this study includes medical group practices, independent practice associations (IPAs), and integrated delivery systems (IDSs). We now provide an overview of the characteristics of these organizations and identify relevant trends concerning their prevalence, size, and organizational structure.

1. Medical Group Practices

The American Medical Association (AMA) defines a medical group practice as, "the provision of health care services by three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records, and personnel are shared. Income from medical services provided by the group is treated as receipts of the group and distributed according to some prearranged plan" (Havlicek et al. 1993). In 1991, the most recent year in which it surveyed medical groups, the AMA

estimated that there were about 21,000 medical groups in the U.S. Seventy-one percent of all medical groups in 1991 were single specialty groups, 22 percent were multispecialty groups, and 7 percent were family or general practice groups (Havlicek et al. 1993).[4] The specialties that accounted for the largest number of single specialty groups were obstetrics and gynecology (OB/GYN), radiology, pediatrics, internal medicine, and orthopedic surgery, which together accounted for nearly half of the single specialty groups in 1991.

Multispecialty groups are much larger on average than single specialty or family/general practice groups. In 1991, multispecialty groups had an average of 25 physicians, while single specialty and family/general practice groups had an average of seven and five physicians, respectively (see Table II.1). Multispecialty groups vary considerably in size. In 1991, 58 percent of multispecialty groups had fewer than 10 physicians, 24 percent had between 10 and 25 physicians, 9 percent had between 26 and 49 physicians, and 9 percent had 50 or more physicians.

Multispecialty groups vary in the physician specialties represented on their staffs, but most have a strong primary care focus. Sixty-eight percent of multispecialty groups in 1991 included physicians who specialize in internal medicine, and 54 percent included physicians who specialize in family/general practice. Internal medicine and family/general practice together accounted for nearly one-third of the physician positions in multispecialty groups in 1991. The next most common specialties represented on the staffs of multispecialty groups in 1991 were pediatrics, radiology, general surgery, cardiovascular disease, and OB/GYN.

In recent years, medical groups have been consolidating at a rapid pace through mergers and acquisitions and have been aligning themselves with hospitals to create various types of IDSs (Lazarus

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[4]Some 21,273 medical groups on the AMA's Group Practice Data Base were determined to be eligible for the survey, of which 12,787 responded (60.1 percent). Analysis of data provided by the respondents indicated that they represented only 11,898 unique medical groups, however, since some respondents represented multiple locations of the same group.

TABLE II.1

DISTRIBUTION OF MEDICAL GROUPS BY GROUP SIZE AND SPECIALTY COMPOSITION, 1991

Group Size	Specialty Composition		
	Single-Specialty	Multispecialty	Family/General Practice
3	25.2%	12.1%	23.0%
4	24.4	13.1	22.2
5-6	25.5	18.0	23.6
7-9	12.5	14.8	12.6
10-15	7.5	13.6	8.6
16-25	3.2	10.2	4.7
26-49	1.2	9.0	2.9
50-75	0.3	3.1	0.9
76-99	0.1	1.6	0.4
100 or more	0.1	4.5	1.1
Mean group size	6.8	24.6	5.2
Sample size	11,247	3,534	1,114

Source: American Medical Association (AMA) survey of medical groups in 1991 (Havlicek et al. 1993).

NOTE: The data in this table are based on 15,895 medical groups, which included (1) 11,898 respondents to the 1991 AMA survey of medical groups, and (2) 3,997 nonrespondents for which recent data on size and specialty composition were available on the AMA's Group Practice Data Base (which provided the sample frame for the 1991 survey).

1994; Shortell et al. 1994; Bohlmann 1992). Steven Lazarus, former Director of Research at the Medical Group Management Association (MGMA), told us that mergers and acquisitions in the previous two years had significantly increased the number of group practices with at least 50 physicians (Lazarus 1994). Thus, the AMA's 1991 survey data probably understate the number of large group practices currently in the U.S.

A notable recent development has been the emergence of investor-owned physician management firms (Day 1993; Freudenheim 1993; Moorhead 1992). These firms buy medical groups and provide them with management expertise, access to capital, and expertise and market power in negotiating contracts with HMOs and PPOs. In 1994, Phycor, the largest physician management firm, owned 22 multispecialty group practices ranging in size from 20 to 50 physicians, all in the Southeast (Crawford 1994). At least seven other physician management firms have been mentioned in the literature, all of which are acquiring multispecialty or family/general practice medical groups. The emergence of physician management firms has the potential for increasing the sophistication and expertise of medical groups in dealing with risk-based payment.

2. Independent Practice Associations (IPAs)

An IPA is an association of physicians that contracts with health plans such as HMOs and PPOs on behalf of its member physicians. The IPA physicians practice individually or in groups, retain ownership of their own practices, and continue to see patients other than those covered by health plans that have contracted with the IPA. The IPA acts as a contracting agent, receiving payments from HMOs and PPOs and compensating its member physicians according to some prearranged plan.[5]

Reliable data are not available on the number or size of IPAs. The American Managed Care and Review Association (AMCRA) lists 161 IPAs in its *1993-94 Managed Health Care Directory*, but

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[5]It is important to distinguish between IPAs and IPA-model HMOs. The latter contract with IPAs, individual physicians, and/or medical groups to provide physician services to the HMO's enrollees.

acknowledges that this list is incomplete due to the difficulty in identifying such organizations (AMCRA 1994). Of the 53 IPAs that reported data to AMCRA on their size, the mean number of physicians was 794. This probably overstates the average size of all IPAs, since larger IPAs were more likely to have been identified by AMCRA. However, these data indicate that at least some IPAs are relatively large.

3. Integrated Delivery Systems (IDSs)

A significant development in recent years has been the trend toward greater integration of physicians, hospitals, and in some cases other providers. Integration has occurred as a means to achieve greater efficiency and cooperation and to facilitate provider contracting with HMOs and PPOs. Many different types of integrated provider organizations have developed, and the growth of these organizations has been dramatic in recent years (Shortell et al. 1994; Ernst & Young 1995). No standard typology has yet been agreed on by either the health industry or health services researchers to define and classify these organizations. We use the term integrated delivery system (IDS) to include the full range of integrated provider organizations discussed in this section. This is consistent with HCFA's use of the term in planning the Medicare Choices Demonstration. However, some industry representatives and researchers use the term IDS more narrowly to refer to organizations at the more fully integrated end of the integration spectrum.[6]

To evaluate the degree of integration in an IDS, Shortell et al. (1994) have defined three types of integration: functional integration, physician-system integration, and clinical integration. Functional integration is achieved when key support functions and activities (such as strategic planning, financial management, data systems, human resources, and quality improvement) are coordinated across the different types of providers in the system. Physician-system integration is achieved when physicians identify with the system and actively participate in its planning and management. Clinical integration,

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[6]Specifically, some researchers and industry representatives do not include physician-hospital organizations in their definition of an IDS.

which is facilitated by the two previous types of integration, is achieved when patient care services are coordinated across the various provider types in the system. IDSs vary considerably in the extent to which (and even whether) they have achieved these three types of integration.

Physician-hospital organizations (PHOs) are the type of IDS that have been forming most rapidly in recent years (PPRC 1995). A PHO is a legal entity formed by a hospital and a group of physicians to act as a collective agent for obtaining contracts with health plans. Physicians maintain ownership of their own practices and agree to accept managed care patients according to the terms of a professional services agreement with the PHO. The physician component of a PHO may consist of individual physicians, medical groups, and/or an IPA. A PHO is analogous to an IPA in that patient revenues generated through the PHO may account for a relatively small percentage of the member physicians' total revenues. PHOs are generally regarded as being at the less integrated end of the IDS spectrum (Burns and Thorpe 1993).

A recent survey by Ernst & Young has yielded new information on the characteristics and strategic objectives of PHOs (Ernst & Young 1995).[7] The survey found that most PHOs are very young organizations. Over half were less than a year old at the time of the survey, and nearly three-quarters were less than two years old. Only 14 percent were more than five years old. Most PHOs include a single hospital, which typically provided most or all of the funds to establish the PHO and retains majority ownership of the PHO. Among the reasons cited as most important for establishing the PHO were contracting with managed care organizations (cited as very important by 88 percent of the PHOs), increasing collaboration between the hospital and the medical staff (77 percent), and enhancing quality of care (63 percent). In addition, 52 percent reported that contracting directly with employers was a very important reason for establishing the PHO. The extent to which PHOs have entered into risk-based payment arrangements is discussed below in section B.

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[7]The survey was conducted in mid 1994. Ernst & Young contacted 250 PHOs nationwide for the survey and obtained data from 189, for a response rate of 76 percent.

A model of physician-hospital integration similar to the PHO is the management services organization (MSO) model (Burns and Thorpe 1993; Ernst & Young 1995). In this model, the MSO is a legal entity owned by the hospital or a group of investors that provides management services to the physicians in the IDS and negotiates contracts with managed care plans. The MSO model differs from the PHO model in a number of other legal and organizational respects that are not critical to this study.

A number of other types of IDSs have been created in which the physician and hospital components are owned by the same entity or by closely affiliated entities. These organizations may consist of a single hospital or of large multihospital systems. Two IDS model types that have been discussed in the literature are the foundation model and the integrated health organization model (Burns and Thorpe 1993). In the foundation model, the hospital creates a not-for-profit foundation that owns and operates one or more medical group practices. The foundation negotiates contracts with health plans on behalf of the hospital and the physicians.[8] In the integrated health organization model, a parent corporation controls a hospital corporation and a medical services corporation, which employs physicians in a network of delivery sites. The parent corporation negotiates contracts with health plans. A number of other types of IDSs have been created, but a commonly accepted typology does not yet exist for classifying them. They include cases in which large hospitals or multihospital systems purchase or contract with group practices, and cases in which group practices own or lease hospital beds (Shortell et al. 1994).

There are no reliable estimates of the number of PHOs or other IDSs currently in the U.S. The American Association of Physician-Hospital Organizations had about 250 PHOs on its membership roles as of March 1995 (Friend 1995). But its membership is dominated by PHOs in the East and South, and it does not claim to include all PHOs in the U.S. A 1993 national survey of hospitals funded by the Prospective Payment Assessment Commission (ProPAC) found that 21 percent of hospitals had formed

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[8]One reason for the popularity of the foundation model is that the surpluses of the foundation are tax exempt (Burns and Thorpe 1993).

either a PHO or a MSO-model IDS, and an additional 9 percent were involved in some other type of IDS (ProPAC 1994). However, since the Ernst & Young survey found that over half of all PHOs in existence in 1994 were less than a year old, the 1993 ProPAC survey almost surely understates the number of hospitals in the U.S. currently involved in some type of IDS.

B. ACCEPTANCE OF FINANCIAL RISK BY PHYSICIAN GROUPS

To assess the feasibility of the Medicare demonstrations considered in this project, it is useful to investigate the extent to which physician groups are currently accepting financial risk from managed care plans. Prior experience accepting financial risk should be regarded as a necessary, though not sufficient, condition for participating in a Medicare demonstration of direct capitation or risk-sharing. The evidence provided in this section indicates that many physician groups have such experience.

The nature of the financial arrangements between physicians and HMOs varies by type of HMO. Researchers have traditionally classified HMOs as staff, group, network, or IPA model plans, which the Group Health Association of America defines as follows (GHAA 1994):

- A staff model HMO delivers health services through a salaried physician group that is employed by the HMO unit.
- A group model HMO contracts with one or more independent group practices to provide health services.
- A network model HMO contracts with one or more independent group practices to provide health services, and the groups also provide care to patients who are not members of the HMO.
- An IPA model HMO contracts directly with physicians in independent practice, with one or more associations of physicians in independent practice (i.e., IPAs), and/or with one or more multispecialty group practices. The HMO is predominantly organized around solo and single-specialty practices, and the physicians also provide care to patients who are not members of the HMO.

The distinctions between these model types are blurring as many HMOs have entered into multiple types of provider contracting arrangements that are characteristic of two or more model types.[9] In addition, several different approaches to defining the four basic model types have appeared in the literature (Nelson et al. 1990).

The following discussion first provides information on the extent to which medical groups, IPAs, and individual physicians are accepting financial risk for enrollees of managed care plans and then describes what is known concerning the extent to which IDSs accept financial risk from managed care plans and employers.[10]

1. Acceptance of Financial Risk by Medical Groups, IPAs, and Individual Physicians

The extent of the financial risk borne by physicians in their arrangements with managed care plans depends on a variety of factors, including: (1) the basic method by which physicians are paid (e.g., salary, FFS, or capitation); (2) the nature of any additional financial incentives, such as risk-sharing and bonus arrangements; and (3) the nature of any risk limitation features. In addition, the level of risk faced by physicians paid by capitation depends on the scope of services covered under the capitation payment, the number of patients over which the risk is spread, and the nature of any risk-adjustment to the payment.

The most current information concerning the financial arrangements between physicians and managed care plans comes from a survey of HMOs and PPOs conducted in 1994 by MPR (Gold et al. 1995). The survey data revealed that, among HMOs that contract with intermediate entities such as medical groups and IPAs for primary care services, about three-quarters of both group/staff and network/IPA model plans

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[9]For example, it is not uncommon for staff model HMOs to add a network or IPA component to expand the size of the geographic areas they serve. In the studies discussed below, HMOs have been classified according to their predominant component--i.e., the component that serves the most enrollees.

[10] Although our primary interest in this section is on the financial arrangements between managed care plans and physician groups, we also include individual physicians in this discussion to present a more complete picture of the extent to which managed care plans place physicians at financial risk.

pay those entities on a capitation basis. A nearly identical result was reported by Hillman, Welch, and Pauly (1992) based on an HMO survey conducted in mid 1988. Neither study examined the scope of services covered under the capitation payment, but it is common for plans to exclude some services (e.g., inpatient hospital care) and use other types of financial incentives (discussed below) to encourage the efficient use of those services (Kongstvedt 1993). Gold et al. found that, in contrast to HMOs, practically all PPOs that contract with intermediate entities pay them on a FFS basis.

The MPR managed care survey data revealed that *individual* physicians are also paid on a capitation basis in a significant percentage of HMOs.[11] Among network/IPA model HMOs, 57 percent of the plans reported that capitation is the predominant method of paying individual primary care physicians, while FFS and salary were the predominant methods reported by 37 percent and 6 percent of the plans, respectively. Among group/staff model HMOs, salary was reported as the predominant method of paying individual primary care physicians by 62 percent of the plans, followed by capitation (34 percent) and FFS (3 percent). Practically all PPOs reported that individual primary care physicians are paid on a FFS basis.

HMOs vary in the scope of services covered under capitation agreements with individual physicians and physician groups. HMOs typically capitate individual physicians only for a defined set of primary care services. Plans typically capitate medical groups and IPAs for a broader range of services--e.g., all professional medical services (Kongstvedt 1993). Some HMOs also include inpatient hospital care among the capitated services for large medical groups or IPAs (Nelson et al. 1990).

It is common for HMOs to use some type of risk-sharing arrangement to provide incentives for physicians to be cost-conscious in the use of services not covered under the capitation payment. For example, HMOs that capitate medical groups for all physician services may place the groups at partial risk for inpatient hospital services through a withholding arrangement. The HMO withholds a portion of the

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[11]The survey investigated the predominant payment method for individual physicians, regardless of whether they are paid directly by the plan or by intermediate entities that contract with the plan.

capitation payment until the end of the year, when it compares the actual costs for inpatient care with the amount it had allocated from premium revenue to pay for such services. If there is a deficit in the inpatient fund, the plan retains the withheld funds to cover the deficit. If there is a surplus, the plan may return some or all of the withheld funds as a reward to the medical groups.

Based on a 1989 survey of HMO managing directors, Hillman et al. (1991) report that about 60 percent of HMOs use a withholding arrangement, and among those that do, 20 percent withhold between 1 and 10 percent of physician payments, 71 percent withhold between 11 and 20 percent, and 8 percent withhold over 20 percent. These findings are based on data from HMOs of all types, not just those that pay physicians on a capitation basis. In an earlier survey of HMOs, Hillman (1987) found that 82 percent of the plans that paid physicians or physician groups on a FFS basis included a withholding provision, compared with 67 percent of those that paid them on a capitation basis. Only 21 percent of the plans that paid physicians on a salary basis (i.e., staff model HMOs) included a withholding provision. Staff model HMOs rely more on bonuses than on withholding arrangements (Kongstvedt 1993).

Some HMOs have developed financial incentive systems for physicians that account for such factors as quality of care and patient satisfaction as well as service utilization and cost. For example, U.S. Healthcare, a large IPA model HMO that capitates individual primary care physicians, pays the physicians a base capitation amount for a defined set of primary care services which can be adjusted upward depending on how the physician scores on various measures of quality, patient satisfaction, and utilization (Schlackman 1993). The plan does not use a withholding arrangement. There is anecdotal evidence that some HMOs that capitate physicians are replacing their withholding arrangements with a bonus system in which bonuses are linked to quality and patient satisfaction measures (*Managed Care Week: Provider Contracting & Capitation*, January 30, 1995). The extent to which this is occurring is not known, but the driving forces are apparently physicians' resentment of withholding arrangements and the desire by HMOs to market themselves to employers as systems that provide high-quality care.

The capitation of providers (i.e., physician groups or individual physicians) may be inequitable if there are systematic differences across providers in the health care needs of their patients, and if such differences are not adequately accounted for through a risk-adjustment to the payment rate. The MPR managed care survey cited above found that 84 percent of the network/IPA model HMOs that capitate individual physicians or physician groups adjust the capitation rate for age and sex, 69 percent adjust the rate for type of payer, but only 18 percent include a measure of health status as a risk adjustor (Gold et al. 1995). The fact that most HMOs use rather simple risk adjustors is not surprising given the challenges of defining risk adjustors based on health status.

Individual physicians or physician groups that accept capitation from HMOs typically have a mechanism in place to limit their financial risk associated with treating patients with high-cost illnesses. For example, HMOs that capitate individual physicians for primary care services and have a withholding arrangement for referrals and inpatient care typically include a stop-loss provision to limit the extent to which referral and inpatient expenses for particular high-cost patients are counted against the physician's balance in the withholding accounts (Kongstvedt 1993). After a patient's referral or inpatient expenses exceed a specified threshold, the HMO may disregard all additional expenses for that patient (or may disregard 80 percent of such expenses) for the purpose of year-end reconciliation of the withhold accounts.

Medical groups and IPAs that are capitated by HMOs for all professional medical services, and perhaps inpatient hospital care as well, typically purchase reinsurance either from the HMO or from an outside insurance carrier. The provider of reinsurance covers medical costs (or a portion of those costs) for individual patients after their costs exceed a specified threshold. The number of insurance carriers that market reinsurance products to medical groups and IPAs has reportedly been growing rapidly. During a six-month period in 1993-94, the number of such carriers reportedly increased from 10 to 25 (Pallarito 1994).

2. Acceptance of Financial Risk by IDSs

PHOs and other types of IDSs vary in their experience with accepting financial risk. The Ernst & Young survey found that the primary source of revenue for most PHOs is discounted FFS arrangements with PPOs (Ernst & Young 1995). These typically do not include a withhold or other type of risk-sharing arrangement. Fifty-two percent of the PHOs surveyed had at least one contract with an HMO, and 63 percent of such PHOs accept capitation from HMOs. About half of the capitated PHOs capitate their hospitals, over 80 percent capitate their primary care physicians, and about 55 percent pay their specialists on a FFS basis. The survey data revealed that PHOs are more likely to develop contracts with HMOs as they become older and more operationally mature.

Additional information on PHO contracting arrangements is provided by a case study analysis of eight PHOs sponsored by the American Medical Association and three state medical societies (AMA et al. 1994). The study sponsors included a broad mix of PHOs that varied along such dimensions as geographic region, size of market area, managed care penetration in the market area, length of time in operation, and predominant type of payment arrangement with health plans (i.e., capitation versus discounted FFS). The study found that the more mature PHOs located in relatively mature managed care market areas tended to have discounted FFS arrangements with PPOs and capitated contracts with HMOs. However, the PHO managers interviewed for this study recommended that PHOs first gain experience with discounted FFS arrangements and then gradually enter into risk-based contracts with HMOs as the organization matures.

The PHOs included in the AMA-sponsored case studies differed in their strategic plans concerning direct contracting with self-insured employers. Some PHOs did not intend to pursue contracts directly with employers because they feared that such action would anger the HMOs and PPOs with whom they had been contracting, which could potentially lead to the loss of such contracts. In addition, in many states the insurance laws are unclear on the extent to which PHOs can accept financial risk, and some PHOs have

been reluctant to test the limits of the laws by contracting directly with employers.[12] On the other hand, some PHOs included in the AMA case studies had entered into direct contracting arrangements with employers, or had plans to do so in the future. Those that had contracted directly with employers had not experienced any adverse consequences, either from the health plans with whom they had been contracting or from state insurance regulators.

Several of the PHOs included in the AMA-sponsored case studies had either formed their own HMO or were in the process of doing so. Most of the PHOs, however, had no plans of ever forming an HMO because they did not want to take on that higher level of risk and/or they feared that such an action would antagonize the HMOs with whom they had been contracting. The PHOs that had formed an HMO had contracts with their own HMO, other health plans (HMOs and/or PPOs), and employers.

It is not known how many PHOs nationwide have contracted directly with self-insured employers or formed their own HMOs, but the health industry trade literature suggests that this is relatively uncommon. The Ernst & Young study discussed above reported that about 14 percent of the PHOs surveyed would like to become a licensed health plan, but it did not indicate whether any PHOs in the sample had already achieved that objective. The study found that direct contracts with employers were a relatively small source of revenues for the PHOs surveyed; it did not examine the nature of those contracts to determine the amount of financial risk accepted by the PHOs. The Ernst & Young study included interviews with the health benefits managers of two major corporations, Chevron and Xerox, both of whom indicated that they do not contract directly with PHOs. The health benefits manager for Xerox indicated that, "the PHOs I've seen would not meet the high standards Xerox requires" (Ernst & Young 1995, p. 14).

The larger, more fully integrated types of IDSs reportedly have greater experience accepting capitated payment than PHOs. The Health System Integration Study, conducted by Shortell and his colleagues, is studying 11 evolving IDSs that began as large hospital systems but added significant physician components

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[12]State insurance laws concerning PHOs are discussed below in section C.

in recent years (Shortell et al. 1994).[13] All but one of the IDSs in this study have full or partial ownership in an HMO or PPO. These IDSs serve enrollees of their own managed care plans, have contracts with other managed care plans (including some fully capitated contracts with HMOs), and treat patients covered under traditional FFS indemnity plans.

C. LEGAL AND REGULATORY ISSUES CONCERNING IDSs

The growing number of PHOs and other types of IDSs that are accepting financial risk from HMOs and self-insured employers has become a major concern of insurance regulators. There is significant variation across states concerning how, and even whether, IDSs are regulated. Many states require that if an IDS accepts risk directly from an employer, it must obtain an HMO license (Ernst & Young 1995). The National Association of Insurance Commissioners (NAIC) distributed a draft bulletin to all 50 state insurance commissioners in summer 1995 advising them that unlicensed IDSs should be permitted to accept risk only from licensed entities like HMOs, and not from employers (*Managed Care Week*, August 21, 1995). Some state regulators are also concerned about arrangements in which an HMO transfers the risk for all health services to an IDS. For example, the Pennsylvania Department of Insurance has proposed regulations that would specify the conditions under which such arrangements would be accepted. These regulations require that IDSs meet certain financial solvency standards and have in place certain consumer protections (*Managed Care Week*, February 13, 1995). Minnesota and Iowa have enacted specific licensing mechanisms for IDSs that require them to meet financial solvency standards and other requirements that are less stringent than those imposed on HMOs (Ernst & Young 1995).

The NAIC is currently developing a Model Uniform Licensing Act that would provide a model regulatory framework for all health plans accepting financial risk--i.e., HMOs, PPOs, indemnity insurers, PHOs, and other types of IDSs. Most states have adopted the NAIC's Model HMO Act (a set of standards

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[13]The systems included in this study range in size from 4 to 14 hospitals.

for regulating HMOs) (Hansen and Carneal 1993), so this current effort by the NAIC is expected to lead to more uniform regulation of PHOs and other IDSs across states. As we discuss in the following chapter, state insurance regulations should be carefully considered in assessing the advisability of a Medicare demonstration that would put medical groups, IPAs, PHOs, or other IDSs at financial risk for Medicare patients.

III. ASSESSMENT OF RISK-BASED PAYMENT METHODS FOR PHYSICIAN GROUPS UNDER MEDICARE

Health maintenance organizations (HMOs) participating in the Medicare risk program can transfer risk to contracting physician groups through the various approaches described in the previous chapter. In this chapter, we assess whether it would be advisable for HCFA to conduct a demonstration in which physician groups would enter into risk-based payment arrangements directly with the Medicare program--without an HMO, PPO, or other licensed insurance plan acting as an intermediary. We also discuss key design issues that would have to be addressed in developing such a demonstration. We evaluate three types of payment options for placing physician groups at some level of financial risk under Medicare:

1. Capitation for some or all Medicare services, possibly with a risk-sharing arrangement between HCFA and the groups for noncapitated services
2. Blended capitation and fee-for-service (FFS) payment rates for some or all Medicare services
3. Incorporation of a risk-sharing arrangement between HCFA and the groups into the existing FFS system

The first two types of payment systems would require an enrollment-based demonstration--i.e., beneficiaries in the demonstration site(s) would face an explicit choice of whether or not to enroll in a participating physician group. Such physician groups would assume responsibility for providing, or arranging for the provision of, a defined set of Medicare services to their enrollees. Depending on the design of the payment system, the groups would have incentives to manage all, or some portion of, their enrollees' care. By enrolling in such a group, beneficiaries would agree to abide by the terms of the enrollment contract, just as enrollees of HMOs, PPOs, and point-of-service (POS) plans must abide by the terms of the contract with their plan. For example, physician groups might offer a managed care product based on an HMO model, in which enrollees would be "locked-in" to the physician group and its approved

provider network for all Part B services or, depending on the payment system design, for all Medicare services. Alternatively, some physician groups might offer a product based on a PPO or POS model, in which enrollees would retain some coverage for services received outside the group and its approved provider network but would face higher cost-sharing for such services.

The incorporation of a risk-sharing arrangement into the FFS system (the third option listed above) could be implemented under either an enrollment-model or nonenrollment-model demonstration. The practice-level volume performance standard (VPS) model developed by Tompkins et al. (1995) and described above in Chapter I is an example of such a payment system based on a nonenrollment model. In this report, we consider both enrollment-model and nonenrollment-model approaches for incorporating a risk-sharing arrangement into the FFS system.

In section A we review an earlier project funded by HCFA in which MPR, with the Medical Management Association (MGMA) as a subcontractor, designed a demonstration of direct capitation to medical groups under Medicare. This review is included because some of the key issues in the current project were explored in the previous project, and in some respects the current project is an extension of the previous project. In section B, we describe the payment options under consideration in this project, and in section C we discuss how the choice of payment option(s) for a demonstration would depend on the types of market areas and physician groups that would be included. In section D, we evaluate the various payment options using the criteria outlined in Chapter I.

A. PRIOR MEDICAL GROUP CAPITATION DESIGN PROJECT

In 1986-87, MPR and MGMA developed a design and implementation, monitoring, and technical assistance plan for a demonstration of direct capitation to medical groups under Medicare (Langwell et al. 1987).[14] Two payment methods were considered for the demonstration: (1) full capitation for both Part

[14]This earlier project focused on direct capitation of medical groups and did not include IPAs or IDSs.

A and Part B services; and (2) full capitation for Part B services, with a risk-sharing arrangement between HCFA and the groups for Part A services. Under the latter approach, HCFA would have established a Part A risk pool for each participating medical group, with the amount in the pool equal to projected Part A FFS costs for the group's Medicare enrollees absent the demonstration. These projected Part A costs would have been based on the Adjusted Average Per Capita Cost (AAPCC) methodology that HCFA uses to set capitation rates for Medicare risk HMOs.[15] At the end of each year, HCFA would have compared the actual Part A payments for each group's enrollees with the projected payments, and HCFA and the group would have shared equally in any surpluses or deficits in the group-specific risk pool.

The final demonstration design recommended full capitation for both Part A and Part B services as the payment method because it had greater potential to contain costs and was the method preferred by HCFA and the majority of the groups that were interested in participating. It was recognized that if medical groups were fully capitated for Medicare services, a mechanism would be necessary to limit their financial risk. Otherwise, they could incur large losses and perhaps become insolvent--a risk that would be a significant deterrent to participation in the demonstration. The risk of large financial losses could also compromise the quality of care delivered to enrollees; for example, it could create financial incentives for medical groups to withhold necessary care from enrollees with high-cost illnesses or otherwise skimp on care.

Medical groups operating under a fully capitated payment system would face three types of risk:

1. Risk of excessive losses associated with the care of individual enrollees with catastrophic illnesses

2. Risk of excessive losses due to enrolling large numbers of beneficiaries who, though not catastrophically ill, incur higher costs on average than predicted by the capitated payment amount ("adverse selection")

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[15]AAPCC payment rates are based on actuarial estimates of average Medicare costs in the FFS sector. For a particular beneficiary, the AAPCC depends on county of residence, age, sex, reason for entitlement to Medicare, institutional status (whether or not a nursing home resident), and Medicaid status.

3. Risk of excessive losses due to poor management, inaccurate actuarial projections, or ineffective utilization controls

The demonstration design sought to limit the first and second risks through a reinsurance mechanism, provided either by a private reinsurance firm or by HCFA. The third type of risk could be minimized by setting appropriate criteria for selecting medical groups for the demonstration.

In general, reinsurance is a mechanism for insurers to limit their risk by sharing risk with another entity. In the past, two types of reinsurance policies were available in the private market: per risk and aggregate (Bovbjerg 1992). Under per risk reinsurance, the reinsurer covers losses for a particular individual that exceed a specified threshold, and the primary insurer retains the risk for all losses below that threshold. Under aggregate reinsurance, the reinsurer covers the losses for an entire collection of risks (e.g., all individuals covered by a certain insurance plan) which as a whole exceed a specified threshold. Although aggregate reinsurance coverage was available in the past, most reinsurers no longer provide this type of coverage because they do not believe it provides sufficient incentives for primary insurers to control total claims costs. Per risk coverage is the only type of reinsurance available to HMOs.

In principle, reinsurance for a demonstration of direct capitation of medical groups under Medicare could be obtained through the private market or provided by HCFA. Preliminary discussions with representatives of a number of firms that are major providers of reinsurance to prepaid health plans indicated that reinsurers were potentially interested in providing per risk reinsurance coverage for a demonstration of full capitation to medical groups (Langwell et al. 1987). Such reinsurance would have covered costs incurred for individual enrollees exceeding a threshold that, depending on the contract, could have been specified in the range of $30,000 to $100,000. Medical groups would have been required to pay a copayment for losses above the threshold. The reinsurers were not willing to provide aggregate reinsurance coverage for such a demonstration. However, they were potentially willing to discuss a

restricted form of aggregate coverage that would have covered aggregate losses on hospital care if utilization exceeded a specified threshold measured in days per 1,000 enrollees.

The demonstration design also required that participating medical groups include a "hold-harmless" provision in their contracts with outside providers (e.g., hospitals and specialists) that would have prevented such providers from seeking payment from enrollees if a medical group became insolvent or for other reasons failed to pay its providers for covered services. The HMO licensure requirements of most states require that HMOs include such provisions in their contracts with providers (Joffe 1993). The demonstration design recommended that HCFA guarantee payment to contracting providers for covered services that were not reimbursed by a demonstration medical group due to insolvency or other failures by the group to meet its contractual obligations. It was assumed that HCFA would, to the extent possible, attempt to recover these costs from the medical group through legal means.

The demonstration design specified a number of criteria related to the capability of medical groups to participate in a demonstration of full capitation under Medicare, including:

- At least five years of operational experience
- A management information system (MIS) capable of monitoring service use by individual patients and overall financial performance
- An existing quality assurance (QA) program, a willingness to modify the program if necessary to meet uniform demonstration standards, and a willingness to accept an external quality monitoring and/or accreditation program
- A significant Medicare patient load and a significant primary care capability
- At least 20 FTE physicians in the group[16]
- Prior experience with prepaid health care delivery

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[16]Materials describing the demonstration were mailed to medical groups with at least 10 FTE physicians, but during the project the criterion for selecting groups for the demonstration was specified as a minimum of 20 FTE. This change was recommended by the expert panel for the project, which included an actuary and other industry experts. It was believed that 20 FTE was the minimum size necessary to permit adequate risk spreading.

- No more than 50 percent of the group's patients covered by Medicare or Medicaid

The final criterion is analogous to HCFA's "50/50 rule," which requires that Medicare and Medicaid enrollees constitute no more than 50 percent of the total enrollment of Medicare risk HMOs. In addition to other quality assurance measures used by HCFA, this rule is designed to protect Medicare and Medicaid beneficiaries from poor quality care. Since some Medicare and Medicaid beneficiaries may be less discerning about the quality of care they receive than the commercially enrolled population, this rule uses an HMO's ability to compete with other plans for commercial contracts as one measure of whether it provides acceptable care and has other attributes associated with enrollee satisfaction. It is debatable whether the 50/50 rule should be applied to a demonstration involving physician groups accepting financial risk from Medicare, since the rule could potentially eliminate groups that specialize in treating conditions that are prevalent in the elderly.

Because HCFA wanted to avoid disrupting the Medicare HMO program, the demonstration design specified that medical groups would be excluded from participation if they (1) contracted with a Medicare risk HMO to provide services to a significant proportion of the HMO's Medicare enrollees, or (2) owned or had other substantial legal involvement in an HMO. These restrictions would have eliminated the medical groups most qualified to participate in the demonstration--i.e., groups with significant experience providing care to Medicare beneficiaries on a capitated basis. Whether these restrictions should be imposed in any future demonstration of risk-based payment for physician groups is a key issue we discuss below.

The demonstration design included a plan for MGMA to provide technical assistance to the participating medical groups to minimize their risk of incurring financial losses, to lessen the likelihood of the demonstration encountering administrative or operational problems, and to assure that high quality care would be provided. The specific areas in which MGMA would have provided technical assistance included:

- Coordination with HCFA on such issues as enrollment and disenrollment procedures, the process for HCFA review of marketing materials, and understanding the AAPCC methodology
- Contract negotiation with other providers
- Development or enhancement of financial and management information systems
- Physician and nonphysician education
- Utilization monitoring and review program
- Quality assurance programs
- Strategic planning, benefit design and actuarial issues, marketing, and patient education
- Legal issues

This project did not proceed beyond the design phase.

B. DESCRIPTION OF THE PAYMENT OPTIONS UNDER CONSIDERATION

In this section, we describe three major payment options for placing physician groups at financial risk under Medicare: (1) capitation, (2) blended capitation and FFS, and (3) FFS with a risk-sharing arrangement. A detailed analysis of the feasibility and desirability of paying physician groups using these methods is presented below in section D

1. Capitation

There are several approaches to capitating physician groups under Medicare. These approaches vary with respect to the scope of services covered under the capitation payment and the nature of the risk-sharing mechanism, if any, for noncapitated services. Risk-sharing for noncapitated services is especially relevant for payment approaches in which inpatient hospital care and/or specialty referrals are covered outside the capitation payment. In this section we discuss four options for capitating physician groups under Medicare: (1) full capitation for all Medicare services; (2) capitation for Part B services, with risk-sharing for Part A services; (3) capitation for primary care services, with risk sharing for other services;

and (4) full capitation for Part B services, with no risk-sharing for Part A services. Throughout this section, we assume that capitation rates would be set using the AAPCC methodology. Other approaches that could be used to set capitation rates are discussed below in section D.

a. Full Capitation for All Medicare Services

If the capitation payment covered all Part A and Part B services, Medicare beneficiaries would enroll in a capitated plan offered by a physician group in much the same way that beneficiaries currently enroll in Medicare risk HMOs. In exchange for monthly capitation payments from HCFA, the physician groups would be responsible for providing, or arranging for the provision of, all Medicare-covered services. This payment option is expected to offer greater potential for cost savings than the other approaches because physician groups would face financial incentives to be cost conscious in the use of *all* Medicare services. Potential sources of cost savings include: substitution of ambulatory care for inpatient care, increased provision of preventive care, greater coordination of care, improved management of patients with chronic conditions, less duplication of services, and less use of specialty care. Covering Part A services under the capitation payment would be a key to achieving cost savings, since prior research has shown that reductions in inpatient hospital care are a major source of the savings in resource costs achieved by Medicare HMOs (Brown et al. 1993).

This payment option would require that the capitated physician groups be able to provide directly or through contractual arrangements with other providers the full range of Medicare services, including inpatient hospital, SNF, and home health care. Developing such contractual arrangements and systems for paying outside providers would require a major investment and thus would effectively limit participation in the demonstration to physician groups that have already made such an investment. The types of physician groups most likely to be interested in, and *potentially* capable of participating in, a demonstration of full capitation for all Medicare services are PHOs, other types of IDSs, and large

multispecialty group practices that have a history of successfully contracting with hospitals (and perhaps other providers) for privately insured managed care enrollees.

Capitating physician groups for all Medicare services would require a reinsurance mechanism to protect groups from the financial risk associated with high-cost patients. We expect that physician groups could obtain per risk reinsurance through private carriers because (1) several reinsurance carriers expressed interest in providing such coverage for the medical group capitation demonstration that MPR designed in 1986-87; and (2) as noted in the previous chapter, growing numbers of reinsurance carriers are marketing reinsurance to physician groups that have entered into risk-based contracts with HMOs. It is doubtful that physician groups could obtain aggregate (as opposed to per risk) reinsurance in the private market, so HCFA might want to consider providing such reinsurance if it is felt that physician groups would need that protection, at least in the initial year or two of the demonstration.[17]

b. Capitation for Part B Services, With Risk-Sharing for Part A Services

Under this payment approach, physician groups would be capitated for the full range of Part B services but payments for Part A services would be made under the regular Medicare program. A risk-sharing arrangement between HCFA and the physician groups for Part A services would provide incentives for the groups to be cost-conscious in ordering Part A services for their patients.

A major advantage of this payment approach over full capitation for all Medicare services is that physician groups would not have to negotiate payment arrangements with Part A providers and process their claims. A larger number of physician groups would therefore be able to participate in a demonstration of this payment approach than in a demonstration of full capitation for all Medicare services.

Operating a risk-sharing arrangement for Part A services would require that HCFA compare actual Part A Medicare payments for demonstration enrollees with projected payments (i.e., the payments that

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[17]As we discuss below, another approach to limiting the financial risk facing physician groups is to use a blended capitation/FFS payment approach rather than straight capitation.

would have been expected absent the demonstration). At year-end, if actual Part A payments for enrollees of a given physician group were less than projected payments, HCFA would share the Part A surplus with the group according to some predetermined formula. The risk-sharing arrangement could be structured to require the physician groups to share in Part A deficits as well as surpluses. One method of doing so would be to withhold a portion of the Part B capitation payment (say, 10 or 15 percent). The physician groups would then be at risk for a portion of any Part A deficits for their patients up to the amount of the withhold. If Part A savings were achieved for a group's patients, the group would receive the withheld funds plus a bonus equal to an agreed-upon percentage of the Part A surplus. Physician groups would clearly prefer to share only in the surpluses, but requiring them to share in both surpluses and deficits would provide stronger incentives for cost control.

Some physician groups might oppose an arrangement in which HCFA would withhold a portion of the Part B capitation payment--particularly groups in areas with below average AAPCCs. Since Medicare's physician fees are already discounted relative to fees paid by many private payers, physician groups might interpret a withhold as an effort by HCFA to further "ratchet down" their fees. PPRC (1995) estimated that in 1995 Medicare will pay physicians on average about 68 percent of the fees paid by private payers. On the other hand, however, some physician groups that are interested in a demonstration of direct risk-based payment under Medicare might prefer a withholding arrangement rather than accepting full capitation for all Medicare services, since it would expose them to less financial risk. HCFA could also consider alternatives to a withhold; for example, HCFA could share surpluses in the Part A fund with physician groups in the manner described above and share deficits by reducing the update to the group's Part B capitation rate in the subsequent year. The willingness of physician groups to participate in a withholding arrangement and their views on alternative arrangements is an issue HCFA could discuss with groups that expressed a desire to participate in such a demonstration.

To determine whether physician groups achieve savings for their enrollees under this payment method, HCFA would need to estimate the Part A costs that would have been incurred by enrollees absent the demonstration. Accurately estimating such costs is difficult, however, because physician groups might attract enrollees that differ in health status from the general Medicare population of their market area (i.e, they might experience biased selection). This issue also applies to the setting of capitation rates. In section D, we discuss the possibility of using risk adjustors other than those currently used in the AAPCC methodology to develop such estimates

c. Capitation for Primary Care Services, With Risk-Sharing for Other Services

This approach would involve capitating physician groups for a defined set of primary care services and using a risk-sharing arrangement such as that described above for other selected services, such as specialty referrals and inpatient care. Depending on how the risk-sharing mechanism is defined, this payment approach could be designed to expose physician groups to less financial risk than the previously discussed payment approaches. This payment approach could therefore be considered for primary care medical groups or relatively small multispecialty groups with a significant primary care practice (i.e., groups that would probably not be able to manage the financial risk associated with the two payment approaches discussed previously).

Under this approach, HCFA could potentially design a single risk-sharing pool in which projected costs for specialty care, inpatient care (and perhaps other services) would be combined, and physician groups would share in any surplus or deficit in the combined pool for their patients. Alternatively, HCFA could design separate risk-sharing pools for specialty care and inpatient care (and possibly other services), which is the approach typically followed by HMOs when they capitate primary care physicians or physician groups (Kongstvedt 1993). Although the second approach would probably be more complex administratively for HCFA, it offers the advantage of allowing HCFA to incorporate different design

features (e.g., different stop-loss provisions) into the risk-sharing arrangements for specialty care and inpatient care.

This payment approach would require that HCFA define the scope of primary care services covered under the capitation payment. Although the line between primary care and specialty care is not distinct, HCFA could define the primary care services covered under the capitation payment in the same manner as HMOs that use this payment method. For example, enrollees in a demonstration physician group would select a primary care physician in the group, and the services covered under the capitation payment would be defined as (1) office visits, and perhaps inpatient visits, provided by those primary care physicians; and (2) a specified set of laboratory and radiology services performed in the offices of such physicians or ordered by them and performed elsewhere. A risk-sharing arrangement for specialty referrals would be necessary under this payment method to counter the financial incentive that capitated primary care physician groups would otherwise have to refer their patients to specialists for services they would previously have performed themselves. This shifting of care out of the capitated environment into the FFS environment would increase Medicare expenditures.

d. Full Capitation for Part B Services, With No Risk-Sharing for Part A Services

This approach would provide weaker incentives for physician groups to contain costs than the payment methods described previously, because physicians would not be at risk for Part A services and would therefore have no incentive to reduce the use of inpatient services. In fact, physicians would have an incentive to shift care from the ambulatory setting to the inpatient setting if possible. This would enable physicians to use resources provided by the hospital, which would be paid under Part A, rather than resources covered under the Part B capitation payment. Thus, the lack of any risk-sharing for Part A services could actually increase Medicare expenditures.

Such a payment method would be straightforward to administer, but it would not provide adequate incentives for physician groups to participate. Since reductions in inpatient costs are a major source of

savings under managed care, physician groups would not be willing to be paid on a capitated basis for Part B services unless the payment system allowed them to share in any Part A savings. (As we discuss below, this was the unanimous opinion of the physician-group representatives we interviewed.) Therefore, we do not regard this payment method as a viable option for a demonstration.

2. Blended Capitation and Fee-For-Service

Under a blended payment approach, physician groups would receive payments from HCFA that depend in part on a capitated rate and in part on Medicare FFS rates. To illustrate, let p be a fraction between 0 and 1 representing the contribution of the capitated rate to the total payment from HCFA and 1-p the contribution of FFS rates. If C is the amount a physician group would receive under straight capitation and F is the amount the group would receive under FFS (for the level of services actually used under the blended rates), then the payment the physician group would receive from HCFA for its Medicare enrollees is as follows:

$$\text{Payment} = p*C + (1-p)*F$$

Newhouse (1986, 1994) has recommended blended rates as a method of paying HMOs, given the inadequacy of currently available risk adjustors to control for biased selection. This payment approach requires that the participating organizations submit claims--something that many HMOs are not currently equipped to do. In this respect, the blended payment system would be well suited to physician groups, since they are accustomed to submitting claims under the Medicare program.

A blended capitation/FFS system would allow HCFA to place physicians at financial risk but it would not expose them to as much risk as straight capitation. For the reasons described above, inpatient hospital services (and perhaps other Part A services) should either be included in the blended capitation/FFS system or should be included in a risk-sharing mechanism of the type described previously.

The level of financial risk placed on physician groups could be varied by adjusting the parameter p defined above; the higher the value of p, the greater the financial risk. The value of p could also be varied across types of services; for example, HCFA may want to place physician groups at less financial risk for inpatient hospital care than for physician services. Furthermore, such a payment system could include a stop-loss mechanism in which the proportion of the payment determined by FFS rates could be increased for individual patients whose claims costs exceed a specified threshold.

3. Fee-For-Service With a Risk-Sharing Arrangement

The final payment option we consider in this chapter would introduce a risk-sharing arrangement between physician groups and HCFA into the regular Medicare FFS payment system. While each of the payment methods described above would require an enrollment-model demonstration, this payment approach could potentially be based on either an enrollment-model or nonenrollment-model design. Under an enrollment-model design, physician groups would be paid on a FFS basis for Medicare services they provide to their enrollees, and a risk-sharing mechanism would provide incentives for the groups to be cost-conscious in treating their enrollees. For the reasons described above, the risk-sharing mechanism would be most effective if it included costs for all Part B services and inpatient hospital care, and HCFA could consider including other Part A services as well. Under the risk-sharing mechanism, HCFA would periodically compare actual costs for each group's enrollees with their projected costs. If actual costs were below projected costs, HCFA and the groups would share in the surplus. If HCFA wanted to require the groups to share in deficits as well as surpluses, it could use a withholding arrangement of the type described above.

This payment approach could also be based on a nonenrollment-model design, although in this case physician groups would have less ability to manage the costs of their patients' care, since their patients would retain complete freedom to self-refer to specialists and other providers. In a nonenrollment-model design, physician groups could not use some of the methods managed care plans typically use to control

costs, such as assigning enrollees to a gatekeeper who is responsible for pre-authorizing all referrals to specialists and hospital admissions. The group-specific VPS model developed by Tompkins et al. (1995) and described above in Chapter I is an example of a nonenrollment design in which a risk-sharing mechanism is incorporated into the FFS system. As part of their study, Tompkins et al. examined the Medicare claims of the patients of 78 physician groups. They found that the Medicare patients of those groups obtained significant amounts of Part B physician and supplier services outside the groups. For each physician group, Tompkins et al. computed the Patient Capture Ratio, which is the percentage of the Medicare Part B payments for physician and supplier services for the group's patients that were paid to that group. The Patient Capture Ratio ranged across groups from 2.9 percent to 52.9 percent and had a mean of 18 percent. Thus, unless the groups could persuade their Medicare patients to obtain a much larger percentage of their care within the group, the groups would have limited ability to control total Medicare costs for their patients.

HCFA's experience with the Medicare PPO Demonstration illustrates the limitations of attempting to manage care under a nonenrollment-model design. One of the participants in that demonstration, CAPP CARE, operated a nonenrollment model PPO. In exchange for an administrative fee from HCFA, CAPP CARE employed its utilization management procedures whenever Medicare beneficiaries obtained care from physicians in its network.[18] MPR's evaluation of the demonstration found that (1) the Medicare patients of CAPP CARE physicians obtained significant amounts of care outside the CAPP CARE network, and (2) CAPP CARE did not have a statistically significant effect on Medicare expenditures (Sing and Nelson 1994).

[18]This demonstration did not involve a formal risk-sharing arrangement between HCFA and CAPP CARE, but CAPP CARE had a clear incentive to try to achieve cost savings in order to persuade HCFA to continue the program and expand it into additional geographic areas (which would have increased CAPP CARE's administrative fee).

In sum, a nonenrollment-model design has both advantages and disadvantages. The main advantage is that it eliminates the need for physician groups to develop incentives to encourage beneficiaries to enroll. However, eliminating the enrollment decision also eliminates the rules of an enrollment contract that would give the physician group much greater ability to manage care (e.g., rules that enrollees must obtain care within an approved network of providers and that enrollees must obtain pre-authorization for specialty referrals and hospital admissions). Without these tools, we believe physician groups would have limited ability to control costs. Therefore, in the remainder of the report we focus primarily on enrollment-model designs.

C. DEMONSTRATION OBJECTIVES AND THE SELECTION OF MARKET AREAS

HCFA's interest in exploring the feasibility of risk-based payment methods for physician groups is based on a desire to give physicians greater incentives to be cost-conscious in their care of Medicare beneficiaries. For example, these payment approaches might prompt physician groups to use the same managed care approaches they use when providing care under risk-based contracts with HMOs. Before assessing the various payment options described above and the advisability of conducting a demonstration to test them, it is useful to consider in greater detail the goals of such an initiative. For example, is the primary goal to introduce new managed care options for Medicare beneficiaries in market areas where there currently is little or no participation by HMOs in the Medicare risk program? Or is the primary goal to expand the range of managed care options available to beneficiaries in market areas where risk HMOs have already achieved a moderate to high penetration rate among the Medicare population? Although both goals could be pursued simultaneously, they have different implications for key demonstration design issues, such as site selection criteria and the types of physician groups and payment options that would likely be included.

1. Conducting the Demonstration in Markets With Little or No HMO Participation in the Medicare Risk Program

Conducting a demonstration of risk-based payment for physician groups in areas where HMOs currently have little or no presence in the Medicare risk program would offer HCFA the potential of introducing risk-based payment in more limited forms (such as capitation for primary care services or FFS payment with a risk-sharing mechanism) in areas where HMOs have not been willing to enter into full Medicare risk contracts. The disadvantage of this strategy is that most physician groups in such areas have little or no experience providing care to Medicare beneficiaries under risk-based payment. However, if the demonstration were conducted in areas where HMOs have a moderate to large presence in the privately insured sector, the likelihood of receiving applications from physician groups with experience with risk-based payment arrangements with HMOs for privately insured enrollees would increase. Based on our discussions with physician-group representatives, we believe that prior experience with risk-based payment would be a desirable prerequisite for participating in a demonstration of risk-based payment under Medicare. Experience with risk based payment was one of the minimum criteria specified in the previous MPR design of a demonstration of direct capitation to medical groups under Medicare (Langwell et al. 1987).

In assessing the feasibility of conducting a demonstration in such market areas, it is useful to consider why the HMOs in those areas have either not entered the Medicare risk program or have achieved low Medicare penetration rates, and whether those factors would also discourage physician groups from participating. For example, some of these areas may have low AAPCC rates. If, as we have assumed, AAPCC rates would be used in the demonstration both to set capitation rates and to set targets for a risk-sharing arrangement, low AAPCCs are likely to discourage physician groups from participating. Thus, interest in a demonstration is likely to be greatest among physician groups in areas with moderate to high AAPCCs. Another factor that may account for little or no HMO participation in the Medicare risk program in some areas is that the elderly in these areas may be unfamiliar with or may dislike HMOs. In such areas,

physician groups may have an advantage over HMOs in enrolling Medicare beneficiaries into managed care, particularly among beneficiaries who have been FFS patients of the groups.

Two of the physician-group representatives we interviewed for this project cautioned that success at managing financial risk for privately insured enrollees does not necessarily lead to success at managing risk for the Medicare population (Hillman 1994; Fischman 1994). They noted that the Medicare and privately insured populations differ significantly with respect to health conditions, comorbidities, service use and intensity, and types of providers needed. Thus, physician groups whose only experience with risk-based contracting has been with privately insured enrollees could endure difficult adjustment periods (and in some cases, failure) in attempting to care for Medicare enrollees under risk-based payment. This suggests that if HCFA proceeds with a demonstration involving physician groups that have no prior experience with risk-based payment for Medicare enrollees, HCFA may want to monitor them more closely or provide greater technical assistance until they gain experience under the demonstration.

2. Conducting the Demonstration in Areas With Moderate to High HMO Participation in the Medicare Risk Program

Conducting the demonstration in market areas where HMOs have a moderate to high presence in the Medicare risk program would offer the advantage that the pool of potential demonstration applicants would likely include physician groups with experience providing Medicare services on a risk basis under contract to HMOs. Such groups would be more qualified to participate in the demonstration than groups without such experience--particularly under the payment methods that involve the greatest financial risk, such as full capitation for all Medicare services or full capitation for Part B services with significant risk-sharing for Part A services. As discussed below, however, our discussions with physician-group representatives suggest that some of these groups--particularly those in competitive markets--might be reluctant to participate in a demonstration of direct risk-based payment from HCFA for fear that HMOs would retaliate by canceling or not renewing their contracts with the groups. Many physician groups rely heavily on

HMOs for both Medicare and privately insured patients, and they might be reluctant to damage their relationships with HMOs for a demonstration project.[19]

Even if some physician groups that currently provide Medicare services on a risk basis under contract to HMOs chose to participate in the demonstration, it is not clear that their participation would significantly increase the percentage of Medicare beneficiaries being treated under managed care arrangements. For example, if HCFA permitted physician groups to enroll their current Medicare patients under contract to HMOs, the demonstration might result primarily in Medicare beneficiaries deciding to disenroll from their HMO and enroll in their physician group.[20] Such switching would not generate any cost savings for HCFA, however, assuming that capitation payments would be computed in the same manner for HMOs and physician groups. In fact, if the physician groups were not fully capitated for all Medicare services but paid under one of the other options described above, costs to HCFA for the "switchers" could be higher than if they had remained in the risk HMOs.

In such market areas, physician groups might attract two other categories of beneficiaries in addition to those who switched from a risk HMO: (1) beneficiaries who would have enrolled in a risk HMO, absent the demonstration; and (2) beneficiaries who would not have enrolled in a risk HMO. HCFA would expect to achieve savings for the second group, but the effects on HCFA's costs for the first group depend on the type of payment option used for the physician groups. If the physician groups were paid under anything less than full capitation for all Medicare services, HCFA might experience a net increase in costs for the first group. Furthermore, introducing such competition could generate significant protests from the HMO

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[19]Some physician groups in markets with little or no HMO participation in the Medicare risk program might also be reluctant to participate in a demonstration for this reason--particularly if the HMOs in these areas are interested in entering the Medicare risk market in the future.

[20]HCFA could implement rules preventing Medicare beneficiaries from switching directly from an HMO to a physician group. However, since beneficiaries can disenroll from an HMO at the end of any month, some could disenroll from their HMO and enroll in their physician group two or three months later, unless HCFA specified that beneficiaries must satisfy a longer waiting period.

industry--particularly if HMOs believed that physician groups were not held to comparable regulatory standards that are appropriate to the level of risk assumed by the groups.

3. Discussion

These considerations suggest that a demonstration of risk-based payment to physician groups under Medicare would have the potential to disrupt the Medicare risk program in areas where HMOs have a moderate to high penetration rate among the Medicare population. On the other hand, however, conducting such a demonstration in areas where HMOs have a more limited presence in the Medicare risk program would likely limit participation to physician groups with little or no experience with risk-based payment for Medicare enrollees. On balance, we believe that if HCFA were to proceed with such a demonstration, it should primarily target sites where HMOs have not already established a strong presence in the Medicare risk market. This strategy would view the demonstration as a means of introducing partial risk payment methods in geographic areas where HMOs have not been willing to enter into full risk contracts under Medicare. If physician groups in such areas were able to succeed under the demonstration, this could encourage HMOs in those areas to enter the Medicare risk market in the future--perhaps under joint ventures with the physician groups or, alternatively, in competition with the groups.

D. ASSESSMENT OF THE RISK-BASED PAYMENT OPTIONS

In this section, we evaluate the feasibility and desirability of the payment options described above using the criteria outlined in Chapter I, which are: attractiveness to physician groups, attractiveness to beneficiaries, potential to control costs without compromising quality of care, absence of regulatory barriers, and reasonableness of administrative burden and cost.

1. Attractiveness to Physician Groups

A key measure of the feasibility of the type of demonstration under consideration is the willingness of physician groups to participate. To obtain the views of physician groups concerning such a

demonstration, we contacted senior representatives of medical group practices, IPAs, PHOs, other types of IDSs, and associations representing these organizations. We were specifically interested in learning about the potential interest of physician groups in such a demonstration, the incentives for them to participate, and any barriers that might discourage them from participating. Senior representatives from the following associations provided their views:

- The Medical Group Management Association (MGMA), which includes about 6,500 medical groups in its membership roles
- The American Group Practice Association (AGPA), which includes about 250 medical groups, many of which are academic medical groups
- The Unified Medical Group Association (UMGA), which includes about 75 medical groups that provide health care services on a risk basis under contract to HMOs
- The American Association of Physician-Hospital Organizations (AAPHO), which includes about 250 PHOs, mostly in the East and South

We also attended a meeting in the Washington, D.C. offices of the Cleveland Clinic Foundation where we described the payment options under consideration in this project and obtained reactions from senior representatives of the following large multispecialty group practices:

- The Cleveland Clinic Foundation, Cleveland, OH
- The Henry Ford Health System, Detroit, MI
- The Mayo Foundation, Rochester, MN
- The Ochsner Medical Institutions, New Orleans, LA
- The Scott and White Clinic, Temple, TX
- The Lahey Clinic, Burlington, MA

The meeting was also attended by the director of government relations for AGPA, of which all of these organizations are members. We also conducted telephone interviews with senior representatives of various

physician groups and physician management companies throughout the country. A list of the persons we interviewed is provided in Appendix A.

a. Discussions With Provider Representatives

We obtained a wide range of responses from senior representatives of physician groups and associations concerning the likely provider interest in a demonstration of the risk-based payment methods being considered in this project. The responses ranged from a lack of interest in any of the payment options to an interest in full capitation for all Medicare services. Among interviewees who expressed interest in one or more of the risk-based payment methods, there was a unanimous opinion that physician groups would participate in a demonstration only if they were at some risk for inpatient care. This reflects the widespread recognition that reductions in inpatient hospital costs are a major source of savings under managed care. The following are comments of selected provider representatives who expressed potential interest in the demonstration:

- The Executive Director of UMGA told us that many medical groups in his association would have a strong interest in a demonstration of direct capitation from Medicare because they are becoming increasingly dissatisfied with the nature of their capitation contracts with HMOs. He said that many medical groups believe HMOs are keeping too high a percentage of their premium revenues for plan administration, executive salaries, and profits. They also believe that capitation payments from HMOs do not adequately compensate them for the risk they assume.

- A senior executive of a PHO commented that some PHOs are currently exploring options for entering the Medicare market, so there is interest in the type of demonstration being considered. He noted that PHOs with experience with risk-based payment and sophisticated data systems could be interested in a demonstration of full capitation for all Medicare services or full capitation for Part B services with a risk-sharing arrangement for Part A services. However, he indicated that his PHO would only be interested in applying for the demonstration if the application process were less onerous than the current application process for the Medicare risk HMO program.

- An IPA administrator told us that some IPAs would be interested in a demonstration of direct capitation for all Medicare services. He expressed some of the same concerns about his IPA's contracts with HMOs as those of the UMGA representative cited above.

- Executives from three physician management companies, PhyCor, MedPartners, and First Physician Care, were interested in the demonstration. Two were most interested in capitation options, while the third was only interested in the risk-sharing option.

Concern about the inadequacy of the current AAPCC methodology was identified as a possible barrier to participation. For example:

- The current chairperson of the Executive Committee of MGMA's Managed Care Assembly[21] (who is also Executive Director of a multispecialty group practice in Washington State) told us that some medical groups would not be interested in any of the payment options if the AAPCC were used to set rates or to set targets for a risk-sharing arrangement. He indicated that physician groups in counties with a low AAPPC rate would have little or no chance of profiting under direct risk-based payment from Medicare since they would be unable to reduce costs below average FFS Medicare costs in the community. He thought that medical groups in communities with relatively high AAPCC rates, on the other hand, might be interested in participating because there would be a profit opportunity.

- The medical group representatives at the meeting held at the Cleveland Clinic Foundation said they would not be interested in any of the payment approaches involving capitation--particularly given the limitations of the risk adjustors currently included in the AAPCC formula.

- A PHO executive also commented that low capitation rates offered by HCFA would discourage participation because it would not make the venture profitable.

The possible disruption of ongoing relationships between physician groups and HMOs was raised as a possible deterrent to physician groups participating in a demonstration of direct risk-based payment from HCFA:

- The President and Chief Executive Officer of Strategic HealthCare Management[22] opined that many physician groups that currently contract with HMOs in competitive markets would not be willing to participate in a demonstration of direct risk-based payment under Medicare because participation would be viewed by HMOs as a competitive threat. This might

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[21]The Managed Care Assembly is an association of medical groups in MGMA that contract with HMOs.

[22]Strategic HealthCare Management is a consulting firm that helps medical groups and less integrated PHOs develop more fully integrated IDSs. It is a subsidiary of Friendly Hills HealthCare Network, a major IDS in California.

prompt the HMOs to retaliate by canceling or failing to renew their contracts with the groups. Physician groups in less competitive markets may be more interested in participating because the threat of retaliation by HMOs would be less serious in such markets. The Executive Director of UMGA agreed that the threat of retaliation from HMOs is a valid concern.

- A past Chairperson of the Executive Committee of MGMA's Managed Care Assembly (who is also the Chief Financial Officer of a large multispecialty group practice in Texas) believed there would be interest in a demonstration only if it didn't interfere with the medical groups' relationships with the HMOs with which they already hold a Medicare risk contract. Because of this potential conflict, it was suggested that HCFA might want to target such a demonstration in markets where no HMOs are currently participating in the Medicare risk program.

Interviewees considered a physician group's experience with risk-based payment arrangements an important criterion for participation:

- Several interviewees suggested that HCFA may not want to enter into risk-based payment arrangements with physician groups under Medicare unless those groups had prior experience with risk-based payment. It was also noted that experience with risk-based payment for a commercial population may not be directly transferable to a Medicare population, since the two populations differ significantly in health status, health conditions, and types of services needed.

- The Executive Director of AAPHO told us that many PHOs in the association were formed within the past two to four years and have not yet gained experience with risk-based contracting. Thus, many of the PHOs in the association may not be qualified to participate in a demonstration of risk-based contracting under Medicare. AAPHO does not include all PHOs in the nation, however.

Two other potential barriers to participation were raised by some of the interviewees-- the possible regulatory burdens associated with the demonstration and the need to ensure that the administrative burden would be minimal. The regulatory burdens pertain to requirements that may be imposed by state insurance departments on physician groups that accept financial risk directly from Medicare--an issue discussed further below.

b. Summary and Implications

These discussions revealed mixed findings concerning the potential interest of physician groups in a demonstration of risk-based payment under Medicare. While it appears that some physician groups would be potentially interested in participating, there are several concerns that would discourage others from participating. Key concerns included: fear of antagonizing the HMOs with which the physician groups contract, concern about the level of the AAPCC rates in some parts of the country, and concern about the inability of the current AAPCC risk adjustors to adequately adjust for biased selection. In the sections that follow, we discuss additional issues that would influence the interest of physician groups in such a demonstration and their ability to participate successfully. These include the ability of physician groups to attract beneficiaries to the demonstration and their ability to perform some of the administrative and financial functions currently performed by the HMOs with which they contract.

2. Incentives for Beneficiaries

Developing incentives to convince beneficiaries to enroll in a physician group would be a key challenge facing the demonstration. If physician groups are at financial risk for their Medicare enrollees, they will most likely want to adopt some of the features of managed care plans, such as restricting enrollees to providers within a designated network (or encouraging them to remain within the network through financial incentives, as in a PPO model), and using various utilization management procedures to control enrollees' use of specialty services, expensive tests, and inpatient hospital care. To convince beneficiaries to accept such restrictions on their care, they would have to be offered something in return.

In considering this issue, it is useful to note that the majority of Medicare beneficiaries have supplemental insurance coverage. The U.S. General Accounting Office estimated that in 1991, 77 percent of the Medicare population had supplemental insurance (GAO 1994). Classified by source of coverage, 30 percent of beneficiaries had one or more plans sponsored by a former employer, 34 percent had one or more individually purchased plans, 4 percent had both an employer-sponsored plan and an individually

purchased plan, 2 percent had Medicaid and some type of supplemental plan, and 6 percent had supplemental insurance from another source or a nonreported source.[23] The remaining beneficiaries had Medicare only (14 percent) or had both Medicare and Medicaid (9 percent).

One way physician groups could attempt to enroll beneficiaries in the type of demonstration under consideration would be to offer a supplemental insurance product that is less expensive than comparable supplemental products on the market. This is how Medicare risk HMOs and Medicare SELECT plans attract enrollees. For example, Medicare risk HMOs provide the full set of Medicare benefits, replace the Medicare deductibles and coinsurance with limited (or zero) copayments, and offer additional benefits such as preventive care, vision care, hearing care, dental care, and prescription drugs. Beneficiaries who enroll in a risk HMO typically obtain these benefits at a lower premium than that charged by comparable FFS supplemental plans (and some HMOs do not charge a premium). Thus, enrollees in risk HMOs accept restrictions on their choice of providers in exchange for a lower premium for supplemental benefits.

Medicare SELECT plans are supplemental products based on a PPO model. Enrollees in a Medicare SELECT plan receive full supplemental benefits only when they obtain covered services from providers in the PPO network. When they obtain services outside the PPO network, they receive reduced (or zero) supplemental benefits, although they retain full Medicare benefits. Thus, like enrollees in private sector PPOs, enrollees in Medicare SELECT plans have some coverage for services received outside the designated network, but they have financial incentives (in the form of lower cost-sharing) to remain within the network.[24]

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[23]These estimates were derived from the Medicare Current Beneficiary Survey.

[24]Many Medicare SELECT plans do not manage the care of their enrollees, however, but seek to reduce their Medigap benefit costs primarily by channeling enrollees to hospitals that have agreed to fully or partially waive the Part A deductible (Lubalin et al. 1994). This approach is not expected to yield cost savings for the Medicare program.

Offering a Medicare supplemental insurance product would be a major challenge for most physician groups. Most physician groups do not have the expertise to develop, market, and manage such an insurance product, so they would need to contract with a consulting firm, an insurer, or an HMO for such expertise.[25] The costs of acquiring this expertise could be a barrier to participation for many physician groups. In addition, as we discuss below, physician groups attempting to market such an insurance product would likely face significant barriers from state insurance regulators. Highly developed IDSs, such as those that have formed an HMO or have a partnership with an insurance company for their private sector business, may be able to offer such a product, but this may not be a feasible approach for smaller physician groups that are not financially integrated with an HMO or insurance company.

If physician groups are not able to offer a supplemental insurance product, we do not believe they could successfully participate in the type of demonstration being considered unless they developed an arrangement with one or more supplemental insurers in which the incentives for beneficiaries to enroll in the group and use the group's providers were incorporated in the terms of a supplemental policy. To understand why, assume that a physician group attempted to attract enrollees by fully or partially waiving the standard Medicare Part B cost-sharing requirements and agreeing to accept assignment on all claims. If these incentives were not somehow coordinated with one or more supplemental insurance products, they would have little effect on the behavior of beneficiaries who have supplemental insurance, who account for just over three-quarters of the Medicare population.[26]

Few beneficiaries with supplemental insurance are likely to switch providers to enroll in a physician group offering a full or partial waiver of Part B cost-sharing, since these beneficiaries are already largely

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[25]For example, the physician groups would need actuarial expertise to predict the costs of Medicare services for their enrollees and the costs of any supplemental benefits they offer, and to determine what premiums (if any) they need to charge enrollees.

[26]Supplemental insurance covers the 20 percent Part B coinsurance, and some policies cover the Part B deductible and some or all of the excess of a physician's charge over the Medicare allowed charge (Rice and Thomas 1992).

protected from such cost-sharing. Thus, among beneficiaries with supplemental insurance, those who enroll in such a group would most likely be drawn from the group's existing Medicare patient base. But this would pose two problems for the group. First, by fully or partially waiving the Part B cost-sharing, the group would lose significant revenues on its existing Medicare patients--revenues that would have come primarily from supplemental insurers rather than patients. Second, under this scenario, the group would have limited ability to manage the care of its Medicare patients who have supplemental insurance, since they would retain full Medicare and supplemental coverage for Medicare services received outside the group's provider network (regardless of whether the group authorized such care). Thus, unlike a private sector PPO, the enrollees in such a physician group with full supplemental coverage would have no financial incentive to remain within the group's provider network. It is unlikely that many physician groups would agree to accept financial risk for such beneficiaries.

An offer by physician groups to fully or partially waive Part B cost-sharing would provide much stronger incentives for the roughly 14 percent of the Medicare population that does not have supplemental insurance and is not on Medicaid. Such beneficiaries could significantly reduce their out-of-pocket costs for Medicare services by enrolling in a physician group, and the waiver of Part B cost-sharing would provide a strong incentive for them to remain within the designated provider network once enrolled.[27] However, if enrollment in the demonstration were open to all beneficiaries, the adverse effects on physician groups from enrolling existing patients with supplemental insurance that we described above are likely to outweigh the benefits of enrolling additional Medicare patients without supplemental insurance. And if physician groups were allowed to restrict enrollment in the demonstration to beneficiaries without supplemental insurance, the relatively small percentage of such beneficiaries in most areas would probably

[27]This financial incentive is likely to be particularly important for this group since, among beneficiaries not on Medicaid, those without supplemental insurance have lower incomes on average than those with supplemental insurance (Nelson et al. 1989).

not allow a physician group to attract enough new Medicare patients to make participation in the demonstration worthwhile from an economic perspective.

We believe that most physician groups would not be interested in the type of demonstration being considered unless they could enroll significant numbers of Medicare beneficiaries (including those with supplemental insurance) and could benefit financially by appropriately managing the care of their enrollees. If physician groups cannot offer a supplemental insurance product, we believe these objectives could best be met if one or more insurers agreed to offer a supplemental product that is coordinated with the demonstration. In principle, a supplemental insurer could reduce its premium for beneficiaries who enrolled in a demonstration physician group, since its expected payments for Part B cost sharing amounts would be reduced or eliminated for such beneficiaries. To provide incentives for beneficiaries to remain within the group's network, the supplemental insurer should also reduce (or eliminate) supplemental benefits if enrollees go outside the network for care. This would create incentives comparable to those of a private sector PPO or POS plan.

This approach would require cooperation and coordination between physician groups and supplemental insurers. Obtaining such cooperation from insurers would likely be difficult since it would require that they devote the resources necessary to develop, market, and administer a supplemental plan for a demonstration in a limited set of market areas. The only financial reward for insurers would presumably be a portion of any savings achieved by the physician groups. We expect that insurers would be much more eager to deal with HCFA directly--e.g., by developing a risk-bearing PPO or other plan for the Medicare Choices Demonstration--than to develop a supplemental product tailored to the needs of one or more risk-bearing physician groups.

Based on these considerations, we believe the most likely way for a demonstration of risk-based payment for physician groups to be implemented successfully is for the groups themselves to offer a supplemental insurance product. The feasibility of such a demonstration is therefore likely to depend on

whether any groups are willing and able to offer such a product, and whether they would be permitted to do so by the insurance regulators in their state.

3. Expected Effects on Costs

As we argued previously, physician groups would have to be at some risk for inpatient hospital care in order for the risk-based payment methods to lead to lower costs of care. The payment methods described above can be classified into two general types, depending on whether inpatient hospital services are (1) covered under the capitation payment to the physician groups, or (2) covered outside the capitation payment but included in a risk-sharing arrangement between HCFA and the groups.[28] In the first type of arrangement, physician groups would need to develop contractual arrangements with hospitals and pay them for services provided to the groups' enrollees. In the second type of arrangement, hospitals would continue to submit claims to fiscal intermediaries and be paid under the regular Medicare program. While PHOs and other types of IDSs may be equipped to handle the first type of arrangement, the second type would be more feasible administratively for most physician groups.

The findings of MPR's evaluation of the Medicare risk program cast doubt on whether physician groups could achieve measurable inpatient savings if hospitals continued to be paid under the regular Medicare program. That evaluation found that risk HMOs reduce inpatient hospital use by reducing lengths of stay (by about 17 percent) but do not reduce admission rates (Brown et al. 1993). This suggests that physician groups are also likely to achieve inpatient savings by reducing lengths of stay rather than admission rates. In a payment arrangement in which hospitals are paid under the DRG system, however, physician groups would have little or no incentive to implement utilization management procedures to

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[28]Two of the payment methods described above fall into the first category: (1) full capitation for all Medicare services, and (2) a blended capitation/FFS system in which the capitation payment covers inpatient services as well as Part B services.

reduce lengths of stay, since the inpatient savings from this effort would accrue entirely to the hospitals.[29] Instead, physician groups would need to reduce admission rates to generate inpatient cost savings for the Medicare program and thus generate a surplus in the hospital risk-sharing fund.

The finding that Medicare risk HMOs reduce hospital days by shortening stays rather than by reducing admission rates is contrary to expectations generated by previous studies, but was supported by other analyses conducted under the MPR evaluation (Brown et al. 1993). For example, an analysis of the quality of inpatient care found that lengths of stay among HMO patients with particular conditions (colon cancer and stroke) were 18 to 23 percent shorter on average than lengths of stay among Medicare FFS patients with the same conditions in the same market areas. In addition, the evaluation case study found that many risk HMOs use case management procedures to reduce lengths of stay--e.g., preadmission planning for each patient by a specially trained nurse, together with the patient's physician, to determine how long the patient should be in the hospital and to arrange for appropriate postdischarge care. The study authors noted that the hospital admission rates among aged Medicare beneficiaries in the FFS sector declined by 25 percent from 1985 to 1989, suggesting that the number of discretionary hospital stays by the elderly has declined significantly and that FFS providers are using new technologies to treat patients on an outpatient basis rather than an inpatient basis. Thus, there may be less opportunity now than in the past for HMOs to save money on Medicare enrollees by reducing admission rates.

These findings suggest that physician groups are likely to be much more effective at reducing inpatient costs if inpatient care is included in the capitation payment rather than under a risk-sharing arrangement in which hospitals are paid under the regular Medicare program. Under the former system, physician

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[29]Physician groups could potentially reduce Medicare payments for inpatient care if they could reduce the number of the patients that exceed the threshold for generating outlier payments. But we expect that such effects would be minimal because (1) hospitals already have incentives to minimize the percentage of their cases that are outliers and to be cost conscious in treating such patients, and (2) it is not clear that physician groups could generate significant reductions in outlier payments for their patients. It is also worth noting that outlier payments nationally constitute only 5 to 6 percent of Medicare PPS payments.

groups would have an incentive to develop payment arrangements with hospitals based on per diems or discounted charges, so they could capture the savings achieved by shortening hospital stays. Under the latter system, however, hospitals would be paid directly from Medicare under the DRG system, so physician groups would have no incentive to use the kinds of approaches used by risk HMOs to shorten hospital stays, since the savings would accrue to the hospitals rather than to the physician groups.[30]

The question of whether physician groups could reduce the resource costs of providing Medicare services is distinct from the question of whether HCFA could achieve cost savings under the demonstration. The answer to the latter question depends on whether the physician groups experience biased selection and, if so, whether the method of setting capitation rates and/or targets for a risk-sharing mechanism includes risk adjustors to adequately control for such selection. The available evidence on the Medicare risk HMO program suggests that this is likely to be an important issue. In the most comprehensive evaluation of the Medicare risk program conducted to date, Brown et al. (1993) found that risk HMOs reduce the resource costs of providing Medicare services but that HCFA pays more for HMO enrollees than it would have paid for them in the FFS sector because the risk adjustors in the AAPCC payment system do not adequately adjust for the favorable selection experienced by the HMOs.

We have assumed throughout this report that the current Medicare patients of any physician group participating in the demonstration would be able to voluntarily decide whether to enroll in the demonstration or to continue using the group under FFS arrangements. We doubt that any physician group would agree to participate in the demonstration if it was required to enroll all of its Medicare patients in the demonstration, since some patients might become angry and switch providers. Thus, the nature and extent of biased selection into the demonstration would depend on the enrollment decisions of the current

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[30]Physician groups could potentially develop arrangements with hospitals in which they would agree to share any savings generated through shorter lengths of stay. We expect that hospitals would be reluctant to devote the resources to negotiate and monitor such arrangements, however, unless they were confident that the physician groups could (1) achieve significant savings and/or (2) significantly increase their Medicare patient load by "channeling" their Medicare patients to those hospitals.

Medicare patients of each participating physician group as well as the enrollment decisions of other Medicare beneficiaries in the group's service area.

It is difficult to predict the nature and extent of biased selection that would exist under a demonstration of risk-based payment to physician groups. We expect it would depend in part on whether physician groups operated under an HMO model in which enrollees would be locked-in to the group's provider network, or under a PPO or POS model in which enrollees would have some coverage for services received out-of-network but would face higher cost-sharing for such services. Under a lock-in model, we would expect favorable selection similar to that experienced by IPA model Medicare HMOs (Brown et al. 1993). Beneficiaries that are being treated for serious illnesses would be less likely than healthier beneficiaries to enroll in a physician group operating on a lock-in model, since they would presumably be less willing to accept restrictions on the specialists and hospitals they could use. This factor may be less important under a PPO or POS model, since in this case enrollees would retain some coverage for out-of-network services. A factor that could contribute to favorable selection under each of these models is that physician groups might encourage their healthier patients to enroll in the demonstration and their sicker patients to remain in the FFS sector.

The evidence from the Medicare HMO program cited above raises questions as to whether the risk adjustors currently included in the AAPCC payment system would adequately adjust for the biased selection that might occur under a demonstration of risk-based payment to physician groups. If the groups experienced favorable selection, this could result in HCFA overpaying them both in the capitated portion of the payment and in the risk-sharing portion. With respect to the latter portion, if the AAPCC rates are used to predict the FFS payments that HCFA would have incurred for enrollees absent the demonstration for the services included in the risk-sharing arrangement with HCFA, and if the groups experience favorable selection not fully accounted for by the AAPCC risk adjustors, the AAPCC rates would overstate the FFS costs HCFA would have incurred for enrollees absent the demonstration. This would lead HCFA

to overestimate the amount of savings in the risk-sharing arrangement and thus overpay the groups under that arrangement.

These considerations suggest that the new risk adjusters developed under HCFA-funded research, such as the Diagnostic Cost Group (DCG) and Ambulatory Care Group (ACG) methods, should be seriously considered if HCFA were to proceed with such a demonstration. These risk adjustors require inpatient and/or ambulatory claims data, which many HMOs would find difficult to provide, but which should not be a problem for physician groups that are accustomed to submitting claims under FFS Medicare.

4. Regulatory Issues

As we discussed in Chapter II, the growing number of PHOs and other types of IDSs accepting financial risk has become a significant concern among insurance regulators. Until recently, IDSs were not covered under the insurance laws of most states. However, when some IDSs began entering into risk-based contracts directly with self-funded employers, state insurance regulators recognized that these entities were in some ways acting like HMOs yet were not subject to the same laws as HMOs concerning financial solvency and consumer protection. Many states have begun regulating IDSs in recent years, and the National Association of Insurance Commissioners (NAIC) is currently developing a Model Uniform Licensing Act that would provide a model regulatory framework for all health plans and IDSs. This is expected to lead to more uniform regulation of IDSs across states.

To investigate the views of state insurance regulators on the types of payment methods being considered in this project, we contacted the NAIC's Washington, DC office. A conference call was arranged with two senior insurance regulators who have played leading roles in NAIC committees

developing regulatory standards for IDSs.[31] Both regulators indicated that if HCFA were to contract directly with physician groups (i.e., medical groups, IPAs, or IDSs) under any of the capitated options being considered in this project, state insurance departments would subject them to regulatory requirements similar to those imposed on HMOs. They specifically mentioned the requirements concerning insolvency protection and indicated that few physician groups would be able to meet those requirements. Therefore, they did not believe that the payment methods under consideration in this project would be a feasible or desirable option for Medicare.

The insurance regulators also indicated that physician groups accepting financial risk directly from HCFA would be viewed very differently from a regulatory perspective than physician groups accepting risk from HMOs. In the latter situation, the HMO is the entity held legally responsible by the state insurance department to ensure that consumers are protected. In the former situation, however, the physician group would be considered the legally responsible entity, which is why state insurance departments would subject the groups to regulatory requirements similar to those imposed on HMOs.

To provide some perspective on these issues, we briefly describe the regulatory requirements that states impose on HMOs concerning insolvency protection.[32] The HMO Model Act developed by NAIC and adopted by twenty-seven states requires that:

- HMOs must have an initial net worth of $1.5 million to obtain a certificate of authority.
- Certified HMOs are required to maintain a minimum net worth that depends on such factors as a plan's premiums and health care expenditures, but is at least $1 million.
- HMOs must deposit $300,000 with the state insurance department. This money is used to protect the interests of HMO enrollees and cover administrative costs if the plan goes into receivership or liquidation

[31]We interviewed Dixon Larkin, Deputy Commissioner, Utah Department of Insurance; and Fred Neppel, General Counsel, Wisconsin Department of Insurance.

[32]This discussion draws heavily from Hansen and Carneal (1993).

We expect that insurance regulators would impose less stringent financial requirements for payment methods that exposed physician groups to less financial risk, but this is an issue HCFA should discuss with the NAIC in the initial planning stages of any demonstration.

5. Administrative Burden and Cost

The feasibility and desirability of implementing a demonstration of direct risk-based payment to physician groups under Medicare depend in part on the administrative burden imposed on the groups and on HCFA. Physician groups are not likely to participate in such a demonstration if it entails administrative costs that they consider excessive. Similarly, HCFA's decision on whether to proceed with the demonstration will depend in part on issues of administrative complexity and cost. We discuss administrative issues relating to three topics: (1) payment issues and beneficiary incentives, (2) reinsurance, and (3) implications for the Medicare VPS.

a. Payment Issues and Beneficiary Incentives

The administrative complexity of the demonstration would depend in part on the payment method selected. Full capitation for all Medicare services, which is the payment method most likely to generate cost savings, would probably be too complex administratively for physician groups that are not organized as PHOs or other types of IDSs. The costs of negotiating payment arrangements with Part A providers and developing and managing systems for paying such providers would be too great an investment for physician groups to make solely for the sake of participating in a demonstration project. Thus, for physician groups other than IDSs, a demonstration of risk-based payment would most likely involve a payment method in which Part A providers are paid under the regular Medicare program. Under some of the payment methods considered in this report, certain Part B providers such as specialists outside the group would also be paid under the regular Medicare program.

A demonstration of a payment method involving a risk-sharing arrangement between physician groups and HCFA would require some administrative changes by HCFA. For example, consider capitation for primary care services with a risk-sharing arrangement for specialty referrals, inpatient hospital care, and perhaps other Medicare services. For this payment system, HCFA would need to implement a system in which the claims for services covered under the risk-sharing arrangement are identified and the associated costs are accounted for in the risk-sharing fund(s). This system would need to be coordinated with the data on demonstration enrollments and disenrollments to ensure that the relevant claims are identified only for services received by beneficiaries while they are enrolled in a demonstration physician group. Such a system would require that the carriers and fiscal intermediaries (FIs) serving the demonstration market area(s) adapt their claims processing systems to enable them to identify claims for demonstration enrollees for services covered under the risk-sharing arrangement.

As discussed previously, we believe that the incentives for beneficiaries to enroll in a demonstration physician group and, once enrolled, to receive their Medicare services primarily within the group's provider network should be incorporated in a Medicare supplemental insurance product. In principle, this supplemental product could either be offered directly by the physician groups or by an insurance company that agreed to market a supplemental product coordinated with the demonstration. We discussed the administrative burdens and other issues associated with these two approaches in detail above and therefore do not repeat the discussion here. But we believe this is a critical issue determining the feasibility of a demonstration of risk-based payment to physician groups.

b. Reinsurance

Under payment methods that expose physician groups to significant financial risk, such as full capitation for all Medicare services or full capitation for Part B services with significant risk-sharing for Part A services, the groups would need to obtain reinsurance coverage. As noted above in section B, we expect that physician groups could obtain per risk reinsurance for the demonstration from private carriers

because several reinsurers expressed potential interest in providing such coverage for a medical group capitation demonstration in MPR's design project in the mid 1980's. In addition, growing numbers of private carriers are marketing reinsurance to physician groups that are operating under risk-based contracts with HMOs. If a demonstration involving multiple physician groups is implemented, HCFA should consider coordinating the purchase of reinsurance for the demonstration from a single reinsurance carrier. Reinsurers are likely to offer a more favorable rate to physician groups if they can spread the risks over all groups in the demonstration and spread the fixed portion of their administrative costs for the demonstration over all the groups.

Alternatively, HCFA could provide reinsurance for the demonstration rather than require that such coverage be obtained from private carriers. For example, HCFA could withhold a fixed percentage of the capitation payment to physician groups (e.g., 2 percent) to fund a reinsurance pool. Or HCFA could fund the reinsurance pool by setting aside an amount above the capitation payments from the Medicare Trust Fund. The latter approach is analogous to a proposal made by the Bush Administration to fund a reinsurance pool for Medicare risk HMOs by setting aside an amount equal to 2 percent of the AAPCC (Wilensky and Rossiter 1991). In its implications for Medicare program costs, this would have been equivalent to raising HMO payments from 95 percent to 97 percent of the AAPCC. Under that proposal, HMOs would have received payments from the reinsurance pool for each enrollee whose costs exceeded $50,000. Those payments would have been equal to 45 percent of the cost in excess of $50,000, and the HMOs would have been responsible for the remaining 55 percent of the excess, which would have provided an incentive for them to continue to manage care for high-cost cases. Simulations by Beebe (1992) suggest that a reinsurance mechanism with those parameters could be funded by an amount equal to roughly 2 percent of the AAPCC.

c. Implications for the Medicare VPS

In some of the payment methods being considered in this project, payment for some or all Part B services would continue to be made under the FFS system. Examples include: (1) blended capitation/FFS; (2) incorporation of a risk-sharing mechanism into the existing FFS system; and (3) capitation for primary care services with a risk-sharing mechanism for other Part B services and Part A services. If a demonstration of these payment methods involved a large number of beneficiaries, or if the demonstration were expanded to a relatively large permanent program, HCFA would need to develop a method for dealing with such payments in the Medicare VPS system.[33]

The Medicare VPS system is designed to provide Congress a mechanism for controlling the growth in Part B payments for physicians' services. It is also designed to provide physicians and physician organizations with financial incentives to develop more cost-effective practice patterns. With input from HCFA and PPRC, Congress specifies a target rate of growth for Part B payments for physicians' services, which is the VPS. If the actual growth in payments differs from the VPS, an offsetting adjustment is made to subsequent payment rate updates.

In a relatively large demonstration of the types of payment methods mentioned above, HCFA would need to decide how the demonstration enrollees and their associated Part B FFS payments should be accounted for in developing the VPS and measuring the actual growth in Part B payments. For example, consider a demonstration in which a risk-sharing mechanism is incorporated into the existing FFS system. The participating physician groups would share in the savings with HCFA if the actual FFS payments for their enrollees were less than the projected payments. We assume that the demonstration enrollees would be included in the development of the VPS--i.e., the enrollees would be included as part of the total

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[33]This issue could be ignored for a demonstration involving a relatively small number of beneficiaries, since the Part B FFS payments for demonstration enrollees would not have a measurable effect on the *national* rate of growth in Part B payments, which is the relevant measure for the VPS system.

Medicare population for which the target rate of growth in Part B FFS payments is established. But how should the actual Part B payments for such enrollees be counted when computing the actual rate of growth in Part B payments nationally?

We believe the best approach in this case would be to include both (1) the Part B FFS payments from HCFA for the services received by the demonstration enrollees, and (2) the portion of the surplus in the Part B risk-sharing fund returned to the participating physician groups as their share of the savings. Thus, the contribution of demonstration enrollees to the actual growth in Part B payments nationally would include all of HCFA's outlays for Part B services for demonstration enrollees--including the portion of any surplus in the Part B risk-sharing fund returned to the physician groups. If the latter payments were not included in calculating the actual growth in Part B payments nationally, HCFA would in effect be sharing this portion of the savings twice with physicians--first, directly with the participating physician groups; and second, through a higher update in physician fees nationally.

This approach would need to be modified somewhat for payment systems that include both capitation and FFS. For example, consider a demonstration in which physician groups are paid on the basis of blended capitation/FFS for all Part B services and have a risk-sharing arrangement with HCFA for Part A services. In this case, the development of the VPS should take into account the number of enrollees participating under such an arrangement and the percentage of their Part B payments that are based on FFS rates (i.e., the expected capitation payments for such enrollees should be excluded from the VPS). Similarly, only the FFS portion of the Part B payments for such enrollees should be included in the calculation of the actual growth in Part B payments nationally. Thus, both sides of the calculation (i.e., the calculation of the target growth rate and the actual growth rate) would be based only on the FFS portion of the Part B payments for demonstration enrollees.

In a demonstration of blended capitation/FFS, HCFA could consider an alternative approach in which demonstration enrollees would be excluded from both sides of the calculation. Thus, the VPS would be

based on the growth in the Medicare population enrolled in Part B--except for those enrolled in the demonstration or in an HMO--and on the expected growth in Part B FFS payments for such beneficiaries. Similarly, actual Part B FFS payments for demonstration enrollees would be excluded in the calculation of the actual rate of Part B payments nationally. This approach may be simpler administratively for HCFA. However, the disadvantage is that the physician groups who participate in the demonstration may be those that have a greater than average ability to adopt new cost-saving technologies and practice patterns, and their experience would be ignored in the process of updating physician fees (and those fees would also apply to the demonstration groups). Thus, this approach might not fully reward physicians and physician groups nationally for their efforts in constraining the volume of Part B services.

IV. CONCLUSIONS

A demonstration of direct risk-based payment to physician groups under Medicare would allow HCFA to test new payment arrangements that could potentially encourage physicians to manage the care of their Medicare patients more efficiently and generate cost savings for the Medicare program. While some of the findings of this report provide reasons to be encouraged about the prospects of such a demonstration, we identified two critical obstacles that would have to be overcome for such a demonstration to become operational. We also identified some issues that could limit the success of such a demonstration.

On the positive side, the growing extent to which physician groups are accepting financial risk from HMOs indicates that many physician groups are experienced at managing such risk. Thus, it is reasonable to consider whether the Medicare program could enter into risk-based payment arrangements with physician groups analogous to the types of arrangements that have developed between physician groups and HMOs. Furthermore, although the physician-group representatives we interviewed were mixed in their views on the demonstration being considered, a number of them expressed potential interest in participating. Thus, if HCFA conducted a two-stage solicitation for such a demonstration, in which the first stage would allow physician groups to express potential interest and obtain additional information, we expect that many physician groups would respond.

We have identified two critical obstacles that would have to be overcome for such a demonstration to be feasible, however. First, state insurance departments would likely impose regulatory requirements on physician groups seeking to participate in such a demonstration that many such groups would be unable to meet. Specifically, the insurance regulators we interviewed for this project felt that, except for large integrated delivery systems (IDSs), few physician groups would be able to meet the requirements concerning insolvency protection that state insurance departments would likely impose.

The Medicare Choices Demonstration will provide HCFA an opportunity to learn more about the ability of IDSs seeking to accept financial risk under Medicare to satisfy the concerns of state insurance regulators. HCFA has indicated that IDSs (and other provider-sponsored organizations) must meet state licensure requirements to participate in the Choices demonstration--or, in the absence of appropriate state licensure laws, they must contact the relevant regulatory authority to seek guidance concerning the safeguards necessary to participate. The experiences of IDSs seeking to participate in the Choices demonstration will provide useful information on the concerns of state insurance regulators, on the requirements they impose on IDSs and how those requirements vary by state and by the amount of financial risk assumed by the IDSs, and on the success of different types of IDSs in obtaining approval from states to participate in the demonstration. This will provide a basis for assessing the feasibility, from a regulatory perspective, of the type of demonstration considered in this report for physician groups other than large IDSs--such as medical group practices and IPAs.

The second critical obstacle that would have to be overcome for a demonstration of direct risk-based payment to physician groups to be feasible concerns the need for physician groups to offer a supplemental insurance product (or a product analogous to that offered by Medicare risk HMOs that would substitute for supplemental insurance). Physician groups would need to offer such a product in order to provide incentives for beneficiaries to enroll in the group and then, once enrolled, to receive their care primarily (or exclusively) within the group's designated provider network. Thus, demonstration physician groups would need to offer products analogous to those offered by risk HMOs or by Medicare SELECT plans. Most physician groups do not have the expertise to develop, market, and administer such an insurance product, however, so this could be a major barrier to participation for physician groups other than large IDSs that own an HMO or are financially integrated in some way with an insurer. Furthermore, obtaining approval from state insurance regulators to market a supplemental insurance product would also be a significant barrier to participation for most physician groups.

If these two critical obstacles could be overcome, we believe a demonstration of direct risk-based payment to physician groups would be feasible. We assume HCFA would want to distinguish such a demonstration from the Medicare Choices Demonstration by primarily targeting medical group practices and IPAs--and perhaps smaller, less fully integrated IDSs. The Choices demonstration will provide HCFA an opportunity to enter into risk-based payment arrangements with larger, more fully integrated IDSs that are able to provide directly, or through contractual arrangements with other providers, all Medicare Part A and Part B services. Since these larger, more fully integrated IDSs will be tested in the Choices demonstration, we assume HCFA would not make them a focus of the type of demonstration considered in this report.

We have identified some other issues that could potentially hinder the success of a demonstration of direct risk-based payment to physician groups under Medicare. We do not believe these issues are so critical as to prevent HCFA from proceeding with a demonstration to test this type of payment arrangement. HCFA should be aware of these issues, however, in assessing the potential value of such a demonstration and in determining the priority to assign this initiative within its overall demonstration and research agenda. First, the physician groups that would be most capable of participating in this type of demonstration are those that currently provide Medicare services under risk-based payment arrangements with Medicare risk HMOs. A demonstration involving these physician groups could potentially disrupt the Medicare HMO program, however, since it could result primarily in a migration of Medicare beneficiaries from HMOs to the participating physician groups, with little or no net increase in the percentage of beneficiaries enrolled in managed care arrangements. Furthermore, some of the physician-group representatives we interviewed suggested that many such physician groups would be reluctant to participate in such a demonstration, since the HMOs with which they contract would view this as a competitive threat and might retaliate by canceling or failing to renew their contracts with the groups.

These considerations suggest that if HCFA were to implement such a demonstration, it should primarily target physician groups that do not serve significant numbers of Medicare patients under risk-based payment arrangements with HMOs. Prior experience with risk-based payment for other populations should be among the eligibility criteria, however. Such physician groups are likely to require more technical assistance, more careful monitoring, and a longer transition period to become successful at managing financial risk for a Medicare population than physician groups that have already acquired this experience by contracting with Medicare HMOs. The potential advantage of this strategy is that it could provide a vehicle for introducing more limited forms of risk-based payment in market areas where HMOs have little or no participation in the Medicare risk program.

A second issue concerns the trade-offs involved in choosing a risk-based payment method for the demonstration. Full capitation for all Medicare services would provide the greatest incentives for cost control. This approach would likely be very burdensome administratively for many medical group practices and IPAs, however, since it would require that they have contractual arrangements with Part A providers and systems in place for paying those providers. Medical groups that do not already have such systems in place would probably not be willing to invest the resources to develop them for the sake of a demonstration. Thus, for many medical groups, the most feasible risk-based payment methods are likely to be those in which Part A providers would be paid under the regular Medicare program. These include (1) capitation for Part B services, with a risk-sharing arrangement for Part A services; (2) capitation for primary care services, with a risk-sharing arrangement for other Medicare services; (3) blended capitation and FFS for some or all Part B services, with a risk-sharing arrangement for Part A services; and (4) incorporation of a risk-sharing arrangement into the FFS system.

The results of MPR's evaluation of the Medicare risk HMO program raise questions as to whether groups operating under these payment systems could achieve measurable savings in inpatient hospital costs, which is critical since reductions in inpatient costs have been widely cited as a key mechanism

through which managed care plans reduce the costs of care. The MPR evaluation found that Medicare HMOs reduce the number of inpatient days for their Medicare enrollees by shortening lengths of stay rather than reducing admission rates (Brown et al. 1993). But in a demonstration of risk-based payment to physician groups in which Part A providers would be paid under the regular Medicare program, physician groups would have no incentive to try to reduce lengths of stay, since doing so would not reduce the Medicare payments to hospitals under the DRG system.[34] Thus, a major vehicle by which Medicare HMOs have been found to reduce the costs of care would not be available to physician groups under such a demonstration. Physician groups might be able to achieve cost savings in other ways, however, such as reducing enrollees' use of specialists and expensive tests. In addition, there may be some market areas in which physician groups could reduce admission rates for Medicare beneficiaries.

In sum, we do not believe a demonstration of direct risk-based payment to physician groups has as much potential for success as the Medicare Choices Demonstration, which will involve larger organizations such as IDSs, PPOs, and HMOs capable of providing the full range of Medicare Part A and Part B services. Given the trend in the marketplace toward greater integration of physicians, hospitals, and other providers, we believe that contracting with larger, more fully integrated IDSs holds more promise than contracting with medical groups and IPAs that are not organized as IDSs. Thus, we do not expect that direct risk-based payment of physician groups will become an important contracting vehicle for the Medicare program. HCFA may want to pursue such arrangements on an opportunistic basis through small-scale demonstrations, however, to supplement its other risk-based contracting arrangements and to test such an approach in market areas where HMOs, PPOs, and IDSs are not interested in contracting arrangements such as those being tested in the Choices demonstration.

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[34]However, it might be possible for physician groups to negotiate arrangements with hospitals in which the two would share in any savings generated by utilization management procedures used by the groups to shorten lengths of stay.

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APPENDIX A

PERSONS INTERVIEWED FOR THIS REPORT

PERSONS INTERVIEWED FOR THIS REPORT

1. **Physician Group Associations**

   Steven Lazarus, Director of Research, Medical Group Management Association

   Brent Miller, Director of Government Relations, American Group Practice Association

   James Hillman, Executive Director, Unified Medical Group Association

   Dan Friend, Executive Director, American Association of Physician Hospital Organizations

2. **Medical Groups**

   Vicki Buxton, Past Chair of the MGMA Prepaid Healthcare Assembly Executive Committee and CFO Kelsey-Seybold Clinics, Houston, TX

   Neil Fishman, Chair of the MGMA's Prepaid Healthcare Assembly Executive Committee Executive Director of The Vancouver Clinic, Vancouver, Washington

   Dan Nickelson, Director of Public Affairs, The Cleveland Clinic Foundation

   Bruce Kelly, Director of Government Relations, The Mayo Foundation

   Darlene Burgess, Vice President of Corporate Government Affairs, The Henry Ford Hospital System

   Mark Beckstrom, Director of Government Relations, Ochsner Medical Institutions

   Larry O'Day, Attorney for Hospital Operations, The Scott and White Clinic

   Pam Corradino, Vice President of Hospital Operations, The Lahey Clinic

3. **Physician/Hospital Organizations**

   Marty Hauser, Executive Director, Akron City Health Services

   David Coombes, President of the National Association of Physician Hospital Organizations

   Thomas Meyer, President and CEO, Strategic HealthCare Management (a subsidiary of Friendly Hills HealthCare Network)

4. **Physician Management Firms**

John Crawford, Vice President of Finance, PhyCor

Jeff Winnaker, Vice President of Finance, MedPartners

Kelly DeKeyser, Vice President and General Manager, First Physician Care

5. **Independent Practice Associations**

Thomas Economidis, Administrator, Arizona Samaritan IPA

Branis Pesich, Administrator, DMC Coordinated Health Care

Kate Cunningham, Administrator, Mohawk Valley Partners

Julie Brown, Administrator, Araz Group (formerly Ethix Midwest)

6. **Insurance Regulators**

Randall Madry, former Deputy Commissioner, Managed Care and Health Benefits Division, NC Department of Insurance

Dixon Larkin, Deputy Commissioner, Utah Department of Insurance

Fred Neppel, General Counsel, Wisconsin Department of Insurance

Nicole Tapay, Assistant Legislative Council for Health Policy, National Association of Insurance Commissioners

7. **Government Officials**

Steve Balcerzak and Tony Hausner, Office of Managed Care, HCFA

Jim Jenkins, an official at the California Medical Assistance Commission

Rosemary Cox, an official at California's Department of Health and Human Services

8. **Reinsurers**

Tim Barden, Assistant Vice President of Underwriting, U.S. Benefits

Michelle Fallahi, Underwriting Officer, Fortis Benefits